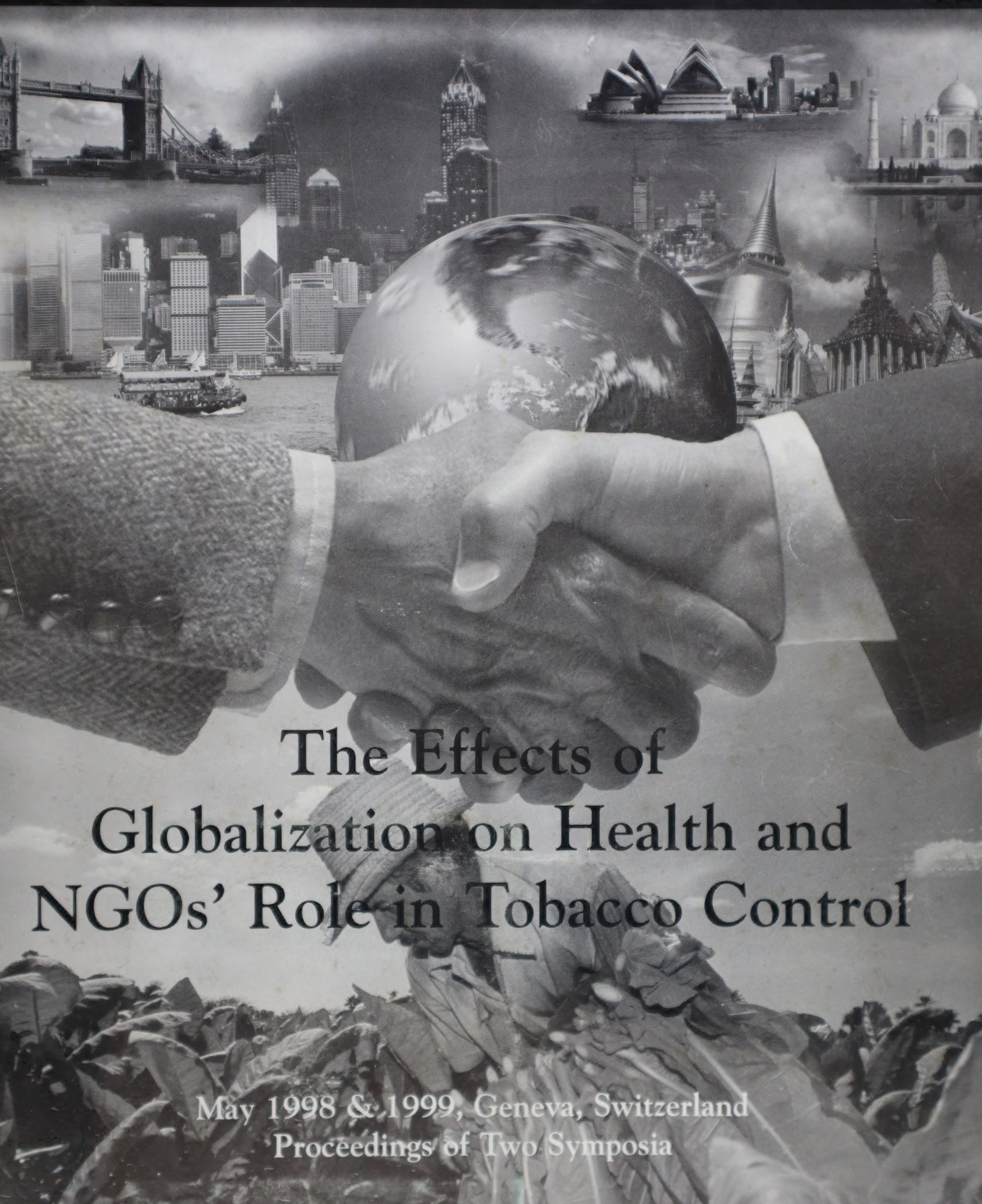
The NGO Forum for Health



The Effects of Globalization on Health and NGOs' Role in Tobacco Control

May 1998 & 1999, Geneva, Switzerland
Proceedings of Two Symposia

Contents

The Effects of Globalization on Health

Report of a Symposium of the NGO Forum for Health
11 May 1998 • Palais des Nations, Geneva
A Special Event to Mark the 50th Anniversary of the Declaration of Human Rights and the 50th Anniversary of the World Health Organization
Co-sponsored by the NGO Forum for Health, the Dag Hammarskjold Foundation and CMC/World Council of Churches

A new kind of citizen is necessary if the human race is to survive. That citizen's loyalty should not stop at anything short of world loyalty.
– G. Brock Chisholm, 1948, First Director-General of WHO

EXECUTIVE SUMMARY
Dr. Elizabeth L. Bowen, Rapporteur

Globalization may be defined as the process of increasing social, political, and economic interdependence and global integration as persons, values, concepts, ideas, capital and products diffuse across national boundaries.

The NGO Forum for Health Annual General Meeting and Symposium on 11 May 1998 at the Palais des Nations in Geneva was a special event to mark the 50th anniversary of the Declaration on Human Rights and the 50th anniversary of the World Health Organization. It was co-sponsored by the NGO Forum for Health, the Dag Hammarskjold Foundation (Sweden), and CMC/World Council of Churches.

The NGO Forum for Health is a Geneva-based coalition of more than 200 international Non-Governmental Organizations (NGOs). It collaborates with the World Health Organization, UNICEF, and other UN agencies on issues of global health, gender, equity, ethics, and social justice. The Dag Hammarskjold Foundation is an independent Swedish institution for innovative and alternative development that organizes seminars and publishes outcomes.

The symposium on Globalization and Health attracted more than 120 representatives of NGOs from all over the world. Its recommendations were presented to the World Health Assembly. The symposium was held in conjunction with the World Health Assembly of the World Health Organization, which was attended by representatives from 186 nations.

Dr. Derek Yach of WHO stated: "The health impacts of globalization, both positive and negative, are key policy issues." The interconnectedness of nations, persons, and services provides an unprecedented opportunity for the global public health community to collaborate on policies and practices across borders to solve common public health problems. More than one million individuals cross national boundaries daily. Travel can contribute to rapid widespread transmission of infectious diseases such as AIDS, and to the export of harmful lifestyles including high-risk sexual behavior, substance abuse, and violence. Global surveillance and increased research on the health impact of globalization are urgently needed. (See D. Yach and D. Bettcher, "The Globalization of Public Health: Threats and Opportunities," in American Journal of Public Health, 88(5) 735-8, 1998.)

Professor Giovanni Berlinguer of the University of Rome described the globalization of disease through "the microbial unification of the world." He recommended a coordinated global effort to combat the health effects of discrimination due to gender, race, ethnicity, religion, or any other human rights violation. The rights-based approach was emphasized, in the context that health is a prerequisite for the full enjoyment of all other human rights.

Professor Davis Sanders of Cape Town, South Africa, stated that globalization is having devastating effects on health in the South. He reported on studies in South Africa and Zimbabwe demonstrating that deterioration of economic conditions is clearly

associated with worsening health status, particularly of women and children. He pointed out that the World Bank's Economic Structural Adjustment Programmes and the Trade-Related Intellectual Property Rights agreement of the World Trade Organization are having profoundly negative impacts on impoverished people, especially in the South. The proposed Multilateral Agreement on Investment is also expected to have negative consequences, if it is implemented. He commended NGOs for their efforts to bring to light and address the harmful relationships between economic policies and health.

Dr. Jose Tiongco, Chief Executive Officer of the Medical Mission Group Hospitals and Health Services Cooperative of the Philippines, presented a case study of a health cooperative system in the Philippines. He stated: "It became clear to us as doctors that ... the real disease was poverty .... Now, through the health cooperative, the poor people, the source of the wealth of nations, are slowly learning to conserve their resources by pooling them together."

Symposium Co-chair **Ms. Renate Bloem**, who also serves as president of the NGO Committee on the Status of Women (Geneva), stated that a rights-based approach must be emphasized because health is a prerequisite for the full enjoyment of all other human rights. She stressed that we must apply systematically the "lens" of a gender perspective to human rights and health and integrate a gender perspective into all aspects of our work.

Symposium Co-chair **Dr. Eric Ram**, who also serves as chair of the NGO Forum, called for WHO to fully implement the existing human rights instruments as they relate to health. The NGO Forum for Health encourages a global coordinated effort to address the health effects of discrimination based on poverty, gender, race, ethnicity, religion, or any other form of human rights violation. Some 1.5 billion people still do not have access to basic health services. Greatly intensified collaboration among NGOs, various institutions of civil society, governments, WHO, and other United Nations agencies to address effectively these huge challenges. Health For All is, in essence, an ethical and moral imperative, as "The earth is but one country and mankind its citizens."

Final Recommendations
The NGO Forum for Health called upon the World Health Organization –

- To establish closer links with NGOs (non-governmental organizations)
- To make a thorough participatory study of the effects of globalization on health and to share the results with the member states and the NGO community
- To take a rights-based approach and implement fully the UN human rights instruments as they relate to health worldwide, including
  - The Universal Declaration of Human Rights
  - The Convention for the Rights of the Child
  - The Convention on the Elimination of Discrimination against Women
  - The Covenant on Social, Economic, and Cultural Rights

THE EFFECTS OF GLOBALIZATION ON HEALTH

INTRODUCTION

Ms. Renate Bloem

Note: Ms. Bloem is President of the NGO Committee on the Status of Women (Geneva), a representative of the World Federation of Methodist and Uniting Church Women, and NGO Forum Coordinating Committee member. She welcomed the participants, some 120 representatives of international NGOs from all over the world. Her remarks follow.

As we commemorate the 50th anniversary of the Universal Declaration of Human Rights and the 50th anniversary of the World Health Organization, one of the key achievements is that we have begun to apply systematically the "lens" of a gender perspective to human rights and health. The affirmation that "women's rights are human rights" came only after a long struggle and hard-won breakthroughs in Vienna at the UN Conference on Human Rights, and in Beijing at the UN Conference on Women and Development. Yet, the first rays of their effective realization have just begun to dawn above the horizon.

The ECOSOC Resolution (1997/3) that mandates the United Nations, including its specialized agencies such as WHO, "to integrate a gender perspective into all aspects of their work" is a major step in the right direction. The NGO Committee on the Status of

Women is actively monitoring WHO's efforts to articulate and implement a gender policy.

The NGO Committee on the Status of Women is also sponsoring a series of open meetings on the effective integration of gender as a central concept in the planning, policies, and programmes of all the UN agencies in Geneva. Our monitoring efforts are part of the follow-up process to insure the timely implementation of the Beijing Platform for Action.

A historic mark was set by the UN Commission on Human Rights, which ended its 54th session here two weeks ago. For the first time in its history, with the strong support of the High Commissioner for Human Rights, Mary Robinson, the Special session on Gender Issues and Human Rights was held, with the invited participation of the chair-person of the New York-based UN Commission on the Status of Women, Patricia Flor. The High Commissioner for Human Rights' Mission Statement on Gender will be released soon.

Throughout the six weeks of the deliberations of the Commission on Human Rights, the NGO Committee on the Status of Women facilitated an ongoing caucus on the human rights of women and girls. This caucus had a considerable impact on the Commission, including its debate, its negotiations, and its resolutions. One outcome of the caucus process was a new item on the Human Rights Commission's agenda, "Integration of the Human Rights of Women and a Gender Perspective," with a sub-item on "Violence Against Women."

During the Commission's deliberations, the NGO Committee on the Status of Women, through our Expert Working Groups, organized several theme-related panel discussions, including "Women's Economic Rights in the Context of Globalization and Trade" and "The Right to Food."

The Commission on Human Rights also gave much higher prominence to economic, social, and cultural rights, a development that is inseparably interconnected with the growing recognition of the importance of women's human rights. One outcome was the decision to appoint a Special Rapporteur, whose mandate is to focus on education, including primary education, with a strong emphasis on gender and girls. Today, the treaty body, the Committee on Social, Economic, and Cultural Rights, is holding its general discussion on "The Effects of Globalization on Social, Economic, and Cultural Rights."

To the term "Globalization," I would add, "Globalization of Human Rights and Globalization of a Gender Perspective."

Dr. Eric Ram, Chairperson of the NGO Forum, who has led us with great vision, is our next speaker.

THE NGO FORUM FOR HEALTH: COMPOSITION AND PURPOSE
Dr. Eric Ram

Note: Dr. Ram is President of the NGO Forum for Health and Director of World Vision International. His remarks are summarized below.

Dr. Ram explained that the NGO Forum for Health is a Geneva-based network of some 200 international NGOs. It collaborates with the WHO, UNICEF, and other UN agencies on issues of global health, equity, ethics, and social justice.

The NGO Forum for Health encourages a coordinated global effort to combat the health effects of discrimination due to gender, race, ethnicity, age, religion, or any other form of human rights violation. This rights-based approach must be emphasized because health is a major prerequisite for the full enjoyment of all other human rights. *Some 1.5 billion people do not have access to basic health care services*. Directing attention to the human rights dimension is of utmost importance to re-frame the debate and to create the moral climate necessary to motivate the UN system and governments to move forward with all due speed to mainstream human rights and gender issues into all policies and programmes. The NGO community plays a leadership role in the process of shaping international public opinion on many subjects, including human rights, the gender perspective, globalization, and the challenges of providing everyone access to good health.

Dr. Ram then reviewed the annual report of the NGO Forum for Health and expressed the hope that the relationship between WHO and the NGO community will go from strength to strength, with increasing intersectoral collaboration. Referring to two previous NGO Forum symposia, "Health for All Means Women and Men" and "Health and Human Rights," he stressed that a gender perspective is fundamental and that poverty is the biggest killer of our time and is, in itself, a profound violation of human rights. Explicit attention to spiritual values is crucial to fulfill the objectives of Health for All. A

Global Health Watch Task Force is seeking funding for a proposed surveillance network to identify and report priority health needs, especially in developing nations.

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Dr. Olle Norbert, Executive Director of the Dag Hammarskjold Foundation, an independent Swedish institution for innovative alternative development, spoke of NGOs as the third system, with government and business being the first two systems. These three systems play complex roles in globalization.

Dr. Kofi Asante, representing CMC/World Council of Churches, encouraged the NGOs to continue to work actively in close collaboration.

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GLOBALIZATION AND HEALTH, THREATS AND OPPORTUNITIES: A GLOBAL PERSPECTIVE

Dr. Derek Yach,
WHO Policy Action Coordination Team

The very creation of the World Health Organization and the United Nations system was based upon a growing awareness of the need for global collective action following the devastation caused by the second world war. The health impacts of globalization, both positive and negative, are key policy issues. The interconnectedness of nations, persons, ideas, services, and products provides an unprecedented opportunity for the global public health community to collaborate on policies and practices across borders to solve common public health problems.

Positive Aspects of Globalization

- Unity in diversity
- Interconnectedness
- Potential to solve problems by collaborating worldwide

However, globalization may also increase threats to health. Historically, the movement of people and trade are intimately linked to increased risk of infectious diseases. More than one million individuals cross national borders daily. Travel and migration can contribute to rapid and widespread transmission of infectious diseases such as AIDS. The export of harmful lifestyles, including high-risk sexual behavior; substance abuse of tobacco, alcohol, and illegal drugs such as cocaine; and violence also influence the distribution of non-communicable diseases and diverse causes of disability and premature death.

Trade in weapons illustrates this point. Sales of both small arms and large-scale weapons delivery systems continue at unacceptably high levels between industrialized and developing countries, despite many international calls for rapid and large reductions in expenditures on weapons. Many countries are now awash with weapons, particularly in the wake of widespread civil unrest and political change. Others are subject to a high level of marketing and media coverage supportive of the use of weapons, through television and the Internet. Recently, an army colonel noted that modern media and video arcade games were more effective in glorifying war and in sensitizing children to the use of weapons than were formal military training programmes. Similarly, the media, not only in explicit advertisements but, more insidiously, in television programming and in movies, projects unhealthy lifestyle role models and stereotypes that glamorize tobacco, to seduce yet another generation of unsuspecting children and youth into addiction to tobacco products.

Negative Aspects of Globalization:

- Risks of loss of diversity and imposed uniformity;
- Worsening extremes of wealth and poverty;
- Further marginalization of disadvantaged groups; and
- The most vulnerable are least able to protect themselves from health threats.

Guiding Principles for Policy Development:

- Be explicit regarding values, principles, and purposes;
- Build national capacity for governance and science;
- Encourage NGO action and linkages locally and globally; and
- Strengthen national and global surveillance, law, and research.

Summary of Policy Implications for Public Health:

- Apply international legal instruments, standard setting, and global norms;
- Promote global intersectoral partnerships: health, trade, finance, environment;
- Enhance global surveillance, monitoring, and assessment;
- Research cost-effective strategies to improve the health status of the poor;
- Focus on appropriate human resource development and public health law; and
- Support global efforts to strengthen national capacities to level the playing field.

INDIVISIBILITY AND GLOBALIZATION OF HEALTH: A PERSPECTIVE FROM THE NORTH

Professor Giovanni Berlinguer,
Universitá "La Sapienza," Rome, Italy

The 20th Ccentury shall be essentially recalled as the time when human society dared to think about health care of the whole human species as a practical objective within its reach.
– Arnold Toynbee

Globalization may be praised as an opportunity for the economic and cultural growth of all peoples that corresponds with the present phase of historical development and can fulfill many requirements. By contrast, the process of globalization can have harmful effects on the cultures, economies, and health of many peoples. What is globalization? How is it managed? By whom? For whom? Where? To what ends? Why? If we view health as a human right as well as a collective concern, what are some of the key moral and historical aspects of globalization? Why do we see growing differences and inequalities in health status among and within most nations?

The World Health Organization has forfeited leadership in health policies worldwide, due to its own internal weaknesses and to the declining commitment of governments. Power and influence have shifted to the World Bank and the International Monetary Fund, especially regarding health policies for developing countries. Unfortunately, the policies of such agencies rarely reflect any explicit sense of moral obligation either to protect or to promote health. The burgeoning tobacco trade provides a vivid example of the absence of any sense of moral responsibility in promoting and distributing a product that is a leading cause of illness, disability, and death.

Health is a cornerstone of economic growth, a multiplier of human resources, and a primary objective of economic growth. Ironically, public health services are often perceived as an obstacle to national wealth, thus reduction in health care expenditures is a top priority for many governments.

Due to communication and transportation, the pursuit of human health cannot be less than global. The notion of world health as indivisible — the founding principle of WHO itself — has been supplanted by a widespread belief, in Europe and the United States, that their citizens could enjoy the best possible health, in separation from the suffering of other peoples. This misconception is largely shared, within each country, by its rich and healthy social groups, unresponsive to the conditions of the disadvantaged groups in their midst.

The model of primary health care as fundamental for the prevention and treatment of disease has been almost abandoned. The trend is toward disbanding public health systems. Even in countries with minimal resources, community health services are increasingly being replaced by private insurance, which, in the U.S. is the least equitable and most expensive system of health care delivery in recent history. In some cases, the government is no longer viewed as being responsible for the health care of the general public, only for the poor.

Globalization of health is on the agenda of the international community. New hopes have been raised for the renewal of WHO, for it to once again become the leading force of the myriad national and international agencies and organizations working for world health. The NGOs are playing key roles in many countries. Women as health players are assuming new roles, dimensions, and importance. The goal of equity in health has given rise to many international activities with the potential for far-reaching influence on health policies, including the Global Equity in Health Initiative, the WHO meetings on Equity and Ethics, and the forthcoming Congress of the International Bioethics Association in Tokyo. This symposium contributes to the same aim and broadens the discourse to diverse NGOs.

Infections, Old and New

Ever since the world is becoming smaller as a result of modern means of communication … human solidarity in the health domain cannot be neglected with impunity.
– Henry Sigerist, Civilization and Disease, 1943.

So dramatic was the reduction in worldwide mortality rates from infectious diseases in recent decades, that an epidemic-free world seemed within our grasp. Most unfortunately, the continued vulnerability of peoples to microbes was confirmed by AIDS, exacerbated by the resurgence of tuberculosis, and highlighted by the discovery and emergence of new and virulent disease agents such as the Ebola virus.

The main explanation given for all such events is the exponential increase in the numbers of men and women traveling at top speed throughout the world. However, international travel, which now involves more than one million people per day, is not only related to tourism and business. Since 1990, some 50 million men, women, and children have been forcibly displaced from their home countries by civil

conflicts, wars, and famine. These ancient, tragic scourges have been constant harbingers of disease throughout history.

Moreover, many infections are spreading as a direct result of human actions. Bovine spongiform encephalitis, BSE, "mad cow disease," became a danger to human health because cattle breeders fed their cattle with sheep meat, viscera, and brains. For the sake of gain, herbivores were converted into carnivores. This opened the way to the novel inter-species transmission of infectious prions, from sheep to cattle to humans.

Tuberculosis is on the rise, not only because it is an opportunistic infection in AIDS patients but also because poverty, urbanization, and marginalization are on the rise. Additional contributing factors include child labor and nutritional deficiencies. The inappropriate and indiscriminate use of anti-microbial drugs has induced drug-resistant strains of tuberculosis. The persistence of malaria and other parasitic diseases may be viewed in light of inadequate investment in vaccine research and development.

These examples lead us to reconsider the concept of "epidemiological transition," — usually defined as the transition from communicable to non-communicable diseases — as being the dominant phenomenon as disease patterns evolve in a given population. In examining the above patterns, they may represent the passage from physiogenic diseases, primarily of natural origins, to anthropogenic diseases, whose origin lies in ourselves, in human behavior, and in our absence of solidarity and of foresight.

Medical Alert for the Environment

Historically, many changes in the environment have led to better health through safe drinking water and sanitation. However, deep damages have appeared as a result of population expansion; excessive consumption; depletion of natural resources; and air, water, and soil pollution, with declining quality of life in most large, crowded urban areas.

A public appeal by physicians and scientists appeared in The New York Times predicting the probable effects of global warming and other types of climate change. They highlighted the likelihood of increased:

- Illness and death from heat waves and air pollution;
- Injuries and death from extreme weather events such as hurricanes;
- Spread of mosquito-borne diseases: malaria, dengue fever, and yellow fever;
- Outbreaks of water-borne diseases such as cholera and childhood diarrhea;
- Vulnerability of safe drinking water due to droughts, flooding, and rising seas;
- Disruption of food production, storage, and distribution; and
- Loss of equilibrium of ecosystems, the biological support systems of all creatures.

In signing this appeal, scientists recognized that "there are many uncertainties in these forecasts, and some of the health effects … may be less severe than anticipated." Even when the severity of damages is unpredictable, we already perceive that many of them, such as extreme weather events related to El Niño, have begun to occur worldwide. Above all, in case of inaction on our side, many of those changes may become irreversible.

The consequences of already established damages and the risks of future environmental changes involve future generations, those human beings who are as yet unborn. Under these conditions, damage/benefit and risk/benefit analyses are out of the question. Even the golden rule of ethics seem insufficient. We may rather rely upon the "responsibility principle" as stated by Hans Jonas, involving both an ethics of proximity and an ethics of distance, where the frame of reference is the world space and the time span that encompasses future generations. The principle of global responsibility implies a power of prediction and prevention that can operate only on the global level and that requires major transformations in public ethics, in international law, and in world governance.

Drug Trade: South to North and North to South

Drug abuse is a fundamental risk to millions of individuals, particularly youth. Addictions not only damage physical, mental, and social health; they are major causes of intentional and accidental injuries and interpersonal violence. Drug abuse is often connected with the presence of organized international crime, which stimulates drug consumption and addiction, channels its huge profits into legal businesses, and contributes to political corruption.

Drug abuse produces both psychological and physical damage that can affect both present and future generations. Many children of alcoholics suffer from post-traumatic stress disorder, a set of disturbing symptoms reminiscent of chronic trauma or "shell-shock." Tobacco use by either parent endangers children as "second-hand smokers." Young children exposed to tobacco smoke get certain infections three times more often and stay sick twice as long as unexposed children. Children

of smokers are also far more likely to smoke than those whose parents do not smoke. Similarly, the risk of "transmitting" alcohol abuse across generations is several times higher for those whose parents abuse it.

Increasing awareness of health and safety risks of drug abuse has started a heated debate. The United Nations Drug Programme in Vienna is a special agency to cope with the problem of drug abuse. Paradoxically, the alarm and most of the proposed actions are targeted against opium, cocaine, and related products that are grown in the impoverished countries of the South and threaten the wealthy countries of the North. What about alcohol and tobacco, which are produced and distributed by the North, and systematically are invading the South?

"The greatest concern for tobacco in the world at the present time is the increasing consumption in developing countries. The tobacco market is decreasing by one percent per year in the West, while increasing by a steady two percent per year in the South. Experts predict that cancer and other tobacco-related illnesses will break out in those countries before transmissible diseases are brought under control, so that the gap separating rich from poor countries will grow even deeper." (World Health Organization)

What are international organizations and governments doing about drug abuse and trade? The European Union has allocated more than $2 billion ($2,000 million) to subsidize European tobacco production and its worldwide export. This is kept quiet. Yet, with considerable fanfare, the EU invested $2 million in the war against cancer, particularly lung cancer. Recently, the U.S. government threatened trade sanctions against four Asian nations that were unwilling to give market access to U.S.-produced cigarettes. In the last few decades, the U.S. government "donated" tobacco seeds worth $700 million to poor countries, with a pledge to later buy their tobacco leaves, within the framework of aid programmes, including "Food for Peace." For the World Trade Organization, limiting the sale of tobacco and alcohol products would be a gross transgression of free trade rules. However, WTO sings a different tune when it comes to opium and cocaine.

Key Questions and Concerns for the International Public Health Community

Can those who are working in health education and health promotion afford to ignore the attitudes and policies that enable these vested interests to work on such a global scale? We are facing powerful multinational organizations that, for their own selfish interests, are promoting behaviors recognized by science as definitely harmful and often lethal.

Are we, as concerned citizens and public health professionals, supposed to think that dissemination of drugs of abuse calls for attention and prompt action only when criminal organizations are involved, whereas trade protection and penal impunity are due when we face industrial corporations, even though they have a more pervasive and destructive global impact on human health?

Finally, what are the United Nations, the World Health Organization, the World Trade Organization, governments, and the Non-Governmental Organizations community in the North and the South doing to cope with this announced massacre, or at least to contain its ravages? At the very least, we can overcome the violence of silence and speak out against the injustices perpetrated against the health of the public, especially youth, merely for the sake of business profits.

Violence in a Public Health Context

It is beyond the scope of this paper to review the "epidemiological patterns" of various forms of violence, yet in almost all countries, violence is the primary cause of death of youth, especially males, and violence destroys the life and the physical and psychological well-being of millions of women, children, and families worldwide. Violence is transmitted as widely as infections, and maybe more rapidly. The basic difference is that no vaccines or medications are available, thus violence is best counteracted by social and cultural antibodies. No physical remedies are known.

Violence cannot be medicalized, even though the medical profession is often called into question, for different and sometimes opposite reasons. Sometimes, organized medicine is even an actor in or an accomplice to violence, by participating in institutional violence. In the former Soviet Union, psychiatry was an effective tool of political repression. In Latin America and other regions, dictatorships and military regimes continue to use physicians as accomplices in torturing political prisoners. Reports of forced sterilization in Sweden continued into the 1960s, and lobotomy was an admitted practice in many parts of Europe until recently. Not only the Nuremberg Code, but the first principle of

the Hippocratic Oath itself: "First to do no harm," "Primum non nocere," are not yet universally applied.

Whenever violence breaks out anywhere in the world, against one gender or one ethnic group, against other ideas in other brains or against a different colour in the skin, driven by ideological or national or religious beliefs, whether directed at specific individuals or randomly targeted as revenge against the world at large; whenever violence appears as organized or generalized crime, in the form of political oppression or as action and reaction, it is hard to imagine that any person may think: "It is none of my business." As an illusion, a person may feel protected, insulated, sitting in a double cocoon of unconsciousness and unresponsiveness. If responsibility is defined as the ability to respond, it is irresponsible not to do so, in the face of the growing epidemic of violence.

Just as drug habits are transmissible by inducing drug consumption, so also is violence transmissible. It is not only through the machinery of criminal organizations and sometimes the states themselves, but also through cultural paths of communication: by imitation, by suggestion, by sensation, through the tensions and strains that violence produces within individuals, families, diverse social groups, and even whole populations.

Faced with violence, as with drug abuse, the main risk is to adopt an attitude of selective rejection or acceptance, determined mainly by prejudice or bias. Transforming this attitude is the most necessary precondition for developing a global approach to violence prevention.

Conclusion

In conclusion, globalization is a positive trend. Any negative perception of globalization relates to its marked imbalance in terms of power relations and ultimate purposes. In terms of power, we cannot accept as unique authority the opinions of the seven or eight wealthiest nations who claim it is their right to decide for the whole world, and of the monetary institutions that claim that all human activity is subservient to their own vested interests. With a positive outlook, the aim is to pave the way to a universal democracy in which the voices of all people and of all interests are heard loud and clear, through organizations such as the UN, WHO, and the NGOs.

In terms of ultimate purpose, the fundamental human rights and the problem of equity should have a central position, after a long period of neglect. Health and safety pertain to this domain, as preconditions to all forms of freedom. Moral values such as universality, solidarity, and justice are often appropriate stimuli for this purpose. We should also think in terms of mutual interest, of mutual advantage. Humanitarianism is a powerful force, but let's not forget another force: convenience. When the two come together, progress is often faster and lasts longer. The aim is not only to distribute in a more equitable way the existing access to health and health care, but to face common threats together and to raise the standard of health of humanity as a whole.

That is what happened at the beginning of the 20th Century. And yet, after the microbial unification of the world in 1643, after the separation of the continents was reduced by communication, more than three centuries were to elapse before the next phase of globalization could begin, with the recognition of mutual dependence. Facing the risks outlined above, we cannot afford to wait three more centuries, nor even three decades.

The vital interests of all peoples and of civil coexistence are at stake, along with the efforts of all persons concerned with health, safety, and quality of life. Short of a reversal of the present trend, we shall all face a deepening dual conflict between morals and practice. On the one hand, we shall be called upon and forced to repair, however late and haphazardly, the predictable and preventable damages inflicted on human health and integrity. On the other hand, we shall do so with more sophisticated technical and scientific equipment, but under more stringent social and economic conditions, with dwindling resources and declining public support. We may even be called upon to decide who is going to live and who will die, selecting individual patients. This presents a moral abyss for all health workers, whose professions are intended to foster and protect all human life. Thus, if this is not to be the reality of our future, as it already is an implicit part of our present, we shall have to work in full consciousness of the risks and opportunities of globalization.

A PERSPECTIVE FROM THE SOUTH

Professor David Sanders, Director,
Public Health Programme, University of the Western Cape, Cape Town, South Africa

Not until the creation and maintenance of decent conditions of life for all people are recognized and accepted as a common obligation of all people and all countries — not until then shall we, with a certain degree of justification, be able to speak of mankind as civilized.
–Albert Einstein

Globalization is having devastating effects on health in the South. The World Bank's Economic Structural Adjustment Programmes and the Trade-Related Intellectual Property Rights agreement of the World Trade Organization are having profoundly negative impacts on impoverished people, especially in the South.

The proposed Multilateral Agreement on Investment is also expected to have negative consequences, if it is implemented. Canadian and Australian public health associations have spoken out against it. NGOs can play a decisive role in attracting the attention of the international community to these issues. Because most governments are submitting to business interests rather than acting in the public's best interest, NGOs must intensify their efforts to expose and publicize the harmful relationships between economic policies and health.

Globalization, defined as the process of increasing economic, political, and social interdependence and global integration which takes place as capital, traded goods, persons, concepts, images, ideas, and values diffuse across state boundaries, is occurring at ever increasing rates. Unfortunately, globalization is proceeding largely for the benefit of the powerful nations.

Essentially, globalization is marginalizing poorer groups in both North and South. In the United States, a clear correlation between income and life span is evident. Survival of men in Harlem, a predominately African-American, severely impoverished region of New York City, is less than for men in Bangladesh. Much of it is violence-related and drug-related, and all of it is inequality-related.

Global distribution of income is highly inequitable. The richest fifth receives 82.7 percent of the total world income; the poorest fifth receives only 1.4 percent of the total world income. Furthermore, the percentage of the population living below US $1.00 per day is increasing, especially in sub-Saharan Africa. The poor are getting poorer and the rich are getting richer.

- Inequalities play a very important role within countries as well as between countries.
- Mortality in developed countries is affected more by relative than absolute living standards.
- National mortality rates tend to be lowest in countries that have smaller income differences and thus have lower levels of relative deprivation.
- Most of the long-term rise in life expectancy seems unrelated to long-term economic growth rates. (Wilkinson, British Medical Journal, 1997; 314:591)

In developing countries, malnutrition is on the rise. The average daily calorie supply per capita in all developing countries is 82 percent of the normal intake level; in sub-Saharan Africa, it is only 67 percent of the amount of energy necessary for adequate nutrition. (UNDP Human Development Report, 1997)

We have now 21st Century technologies in 19th Century social conditions:

- Nearly 1.2 billion people lack access to a safe water supply;
- Some 2.5 billion people lack access to proper sanitation;
- More than 1 billion people lack adequate shelter or housing;
- Six hundred million people live in dwellings that threaten their health; and
- One hundred million people are homeless. (UNDP Human Development Report, 1997)

A recent longitudinal study (Sanders et al.) in Zimbabwe demonstrated that deterioration of economic conditions is clearly associated with worsening health status, particularly of women and children. Its objectives were to measure the changes occurring in health and health services during the implementation of the structural adjustment programme through the monitoring of selected indicators. Its conclusions were that socioeconomic stress produced deterioration of households' economic situation, decline in health care utilization, and a significant increase in malnutrition of young children. These findings were associated with significant macro-economic changes, including a structural adjustment programme. The implications for South Africa, which has recently implemented measures consistent with the World Bank's Economic Structural

Adjustment Programmes are potentially threatening to poor people's health.

In closing, the way the current power structures are organized, they work in favor of the most powerful. What is driving it could be under more democratic control. There is a process of increasing integration. Who is controlling it? NGOs can lead the way to more equitable access to health and health care by influencing the processes of globalization to serve the best interests of the general public.

Ending human poverty requires a democratic space in which people can articulate demands, act collectively, and fight for a more equitable distribution of power. (UNDP Human Development Report, 1997)

THE HIDDEN WAR: A CASE STUDY

Dr. Jose Tiongco,
National Chief Executive Officer, Medical Mission Group Hospital and Health Services Cooperative, Davao City, Philippines

Unless unjust relationships between countries are changed, justice will not prevail.
– Jose Tiongco

Dr. Jose Tiongco, Chief Executive Officer of the Medical Group Hospitals and Health Services Cooperative of the Philippines, presented a case study of why he and his colleagues chose to develop a health cooperative system in the Philippines. He stated: "It became clear to us as doctors that the real disease was poverty. Now, through the health cooperative, the poor people, the source of the wealth of nations, are slowly learning to conserve their resources by pooling them together."

Dr. Tiongco spoke passionately about the need for affordable health care in the Philippines. He stated that under the current system of health care delivery, health care is only for the few who can afford it. He shared literature that is abstracted here, indicated his willingness to respond to further questions by correspondence, and welcomed site visits. Dr. Tiongco's remarks are summarized below.

A cooperative is a socioeconomic institution organized and democratically managed and controlled by individual stakeholders to address a common need by pooling their resources together. A health cooperative is a service cooperative designed to provide affordable health services to its members and the community. The Medical Mission Group Hospitals and Health Services Cooperative is the first and only health service cooperative network in the Philippines. It began in Davoa City in 1991 and has 51 chapters throughout the Philippines.

A health cooperative is started by grouping together at least 15 health workers, including physicians, nurses, medical technicians, and others, who are interested in creating and working in a health facility for the community. Currently, more than 2,000 physicians and thousands of other health workers are employed in 18 cooperative hospitals and five diagnostic clinics.

The professional fees of the physicians and other health workers are determined by the medical staffs of each facility. While recognizing the differences in incomes and lifestyles between the urban and rural areas in the Philippines, the Mission Medical Group strives to strike a reasonable range of professional fees nationwide, with the consent and cooperation of the medical staff members and the communities themselves.

Dr. Tiongco stated that when then Health Secretary Juan Flavier visited the Davao City Cooperative Hospital and the Cooperative Health Programmes, he praised the model programmes as "the wave of the future," and urged their replication nationwide.

Symposium on The Effects of Globalization on Health Final Recommendations

The NGO Forum for Health called upon the World Health Organization:

- To establish closer links with NGOs.
- To do a thorough participatory study of the effects of globalization on health and to share the results with the member states and the NGO community.
- To take a rights-based approach and implement fully the UN human rights instruments as they relate to health worldwide, including:
  - The Universal Declaration of Human Rights;
  - The Convention for the Rights of the Child;
  - The Convention on the Elimination of Discrimination against Women; and
  - The Covenant on Social, Economic, and Cultural Rights.

The NGO Forum for Health Statement to the 51st World Health Assembley

12 May 1998 • Palais des Nations, Geneva
Dr. Eric Ram

Note: Dr. Ram is Director of World Vision International and President of the NGO Forum for Health, a network of more than 200 international NGOs.

On behalf of the NGOs, I wish to express our appreciation for the open, consultative, and participatory approach that the World Health Organization has adopted in preparing Heath for All in the 21st Century and the deliberate attempts to involve and obtain NGOs' input into this process. We endorse this document and WHO commitment to advocate for global health, for health equity between and within countries, and to identify policies and practices that are beneficial or harmful to health. We fully support the emphasis on social justice, equity, ethics, human rights in health, and a gender perspective.

There is a need to develop an adequate infrastructure for proper implementation of the policies and strategies which addresses the main health problems in the countries providing preventive, curative, and rehabilitative health services, including health promotion.

We believe that it is important that in the 21st Century, Health For All (HFA) does not become another slogan but becomes operative. It is for this reason that we are promoting the creation of a Global Health Watch to monitor and to determine how our governments, WHO, and the NGOs alike are fulfilling our HFA responsibilities and to ensure availability and equitable distribution of resources, especially among those countries and communities in greatest need.

We believe that at its heart, Health For All is a moral and ethical imperative. We are pleased that the WHO Executive Board has decided to recommend to the World Health Assembly a modification in the WHO definition of health that will include the spiritual dimension as an essential component of health.

The NGO Forum for Health believes that the partnership between WHO and NGOs is crucial in the realization of the Health For All strategy. For this, we need a stronger structure to nurture and support this new partnership. We therefore recommend the following to the World Health Assembly:

- To strengthen and reformulate appropriate structures, a mechanism needs to be created within WHO to carry on regular consultations and dialogue collectively with the NGOs at global, regional, and national levels. Such mechanisms exist in other organizations, between NGOs and UNICEF and UNHCR.
- To examine and review criteria to qualify for official relations between NGOs and WHO, especially multi-sectoral NGOs that impact on health. This is because WHO's new global health policy clearly recognizes that many of the determinants of health lie outside the domain of the formal health sector and that WHO needs to forge strong partnerships with a wide range of actors of health.

- To request that WHA through its Executive Committee ask for an annual progress report to be presented to the Executive Committee Board on the development of relationships between NGOs and WHO.
- To collaborate with NGOs on the full implementation of the existing UN instruments as they relate to health, including the Convention on the Rights of the Child and the Convention on the Elimination of Discrimination Against Women.

We are deeply concerned that 1.5 billion people still do not have access to basic health care services. While the global trends in macroeconomic policies may stimulate economic growth, they have also resulted in the marginalization of large numbers of people in both developing and industrialized countries.

In our 11 May 1998 NGO symposium on "The Effects of Globalization on Health," the four eminent speakers from the four corners of the world pointed out that globalization is affecting the health of the people both in the North and, more particularly, in the South. Certainly the poor of both North and South are affected adversely. Poverty is the biggest killer today and is a violation of human rights. We therefore ask that WHO undertake a thorough study of the effects of globalization on health and share the results with its member states and the NGO community.

We rejoice and celebrate the many achievements accomplished during the last 50 years in many member states, thanks to the leadership of WHO. We hope that WHO will not only continue to be a leader in health issues but also will become a voice for those who are deprived of health.

This year we are also commemorating the 50th anniversary of the adoption of the Universal Declaration of Human Rights. Health is a prerequisite for the full enjoyment of all other human rights. These rights are universal, indivisible, and interdependent.

Personal change goes hand in hand with social change, and both must be viewed as central to collective progress. Development is a process that encompasses both the spiritual and material aspects of life. Therefore, development must be guided by universal principles and values, and seek to promote quality of life and human dignity.

In his acceptance speech as Secretary General of the UN on December 18, 1996, Mr. Kofi Annan said, "We should demystify the UN and not make it so bureaucratic and distant from the average person. We should bring the organization closer to the people."

The NGO Forum for Health stands ready to work hand in hand with WHO in partnerships at the global, regional, national, and grassroots levels, to bring WHO closer to the people.

NGO Forum for Health Annual Report

Dr. Eric Ram, Chairman
11 May 1998
Geneva

Ladies and Gentlemen,

I deem it a privilege to present to you a summary of the key activities of the NGO Forum for Health, since our last annual general meeting in May 1997. Thanks to the very active involvement and participation of all the members of the Coordinating Committee of the Forum we were able to accomplish a number of objectives and organize a series of meetings and symposia, and enhanced dialogue with WHO.

The NGO Forum for Health has its genesis in the NGO Joint Planning Exercise in PHC in the mid-70s, which has since then undergone several changes in its name. Most commonly it was known as NGO Group on PHC and played a key role in providing NGO input into the preparatory work leading to the development of Primary Health Care Declaration in Alma Ata. In order to discuss the current health needs, to develop a vision for the future and revitalize the Group, in 1997 we set a new vision and changed our name to NGO Forum for Health. We also renewed our commitment and rekindled our enthusiasm to promoting equity and justice in health care and partnering together in making health a reality for all. We remain committed to PHC as a strategy and in the spirit of HFA Strategy decided to be an inclusive Forum of multi-sectoral NGOs.

In his acceptance speech, Mr. Kofi Annan, the Secretary General of the UN on December 18, 1996 said "We should demystify the UN and not make it so bureaucratic and distant from the average person. We should bring the organization closer to the people." He continued, "This organization along with the rest of the world, must change. Let us make change our ally, not our enemy, seize it as an opportunity, not a threat, recognize it as a necessity not an imposition." This applies to WHO and all of us NGOs.

ACTIVITIES

I. Policy Formulation and Development:

- On behalf of NGO Forum for Health your Chair made an intervention both at the '97 WHA/Committee (May 9) and the WHO Ex. Board (May 15) and raised NGO issues and concerns in both the settings, including our NGO initiative in developing and promoting Global Health Watch. We also asked for enhanced formal and informal relationship, better communications, continuous dialogue between NGOs and WHO.

- We met in September 1997 to review the WHO Draft
  Policy Document "HFA in the 21st Century" We expressed our basic support of the document but also made a number of recommendations (5 pages) for incorporation, which we communicated in writing to Dr. Antezana/WHO in October 1997. One of our recommendations was "At its heart HFA is a moral and ethical imperative. We call for a more profound definition of health to include spiritual dimension as an essential component." (We made the same recommendation both in WHA and WHO/EB as well).

- Due to the non-involvement of the NGOs by the WHO either in the process or the recommendations going to the WHO EB in January 1998, we requested for, and got a meeting with, Dr. Antezana and Mr. Aitkins of WHO. We made a number of recommendations for specific changes in the document and also actively lobbied with WHO/EB members in January 1998 for those changes.

OUR MAIN RECOMMENDATIONS WERE:

- To strengthen and reformulate appropriate structures, a mechanism, for NGOs to work collectively with WHO at international, regional, and national levels, to maintain dialogue and briefings between NGOs and WHO (other UN agencies, like UNICEF, UNHCER have already developed such mechanisms).

- To examine and revise the criteria for official relationship between NGOs and WHO, especially multi-sectoral NGOs which have an impact on health.

Our efforts continue and we hope that they will be reciprocated in equal measure.

II. Pursuance of Current Issues and Concerns

In order to identify and discuss current issues which have relevance to NGO Forum members we have organized three symposia over the year. They are:

A. HEALTH FOR ALL MEANS WOMEN AND MEN: A GENDER PERSPECTIVE (OCTOBER 1997)

This symposium organized jointly by the Committee on the Status of Women (Geneva) and the Forum was held at the Ecumenical Center in Geneva (co-chaired by Ms. Renate Bloem and Giovanni Ballerio), which, with its 10 working groups, is very actively involved in the process of following up and mounting the Platform for Action, adopted in Beijing in 1995. There were excellent speakers in this symposium, which provided an opportunity to develop better understanding, deeper knowledge, heightened awareness and increased commitment to deal with the need to apply greater gender perspective on all areas of health. The speakers were: Ms. Miriam Maluwa, Ms. Marybeth Morsink, Dr. Elizabeth Bowen, Dr. Derek Yach, Ms. Marianne Haslegrane (Rapporteur).

B. HEALTH AND HUMAN RIGHTS (APRIL 1998)

This symposium was jointly organized by the Forum and the International Federation of the Red Cross, held at the WHO It was chaired by Dr. Ali Reza Mahallati of IFRC. There were four excellent speakers. Right to highest attainable standard of health has to be seen in the context of human rights values, equity, non-discrimination, access, dignity, autonomy, participation, and freedom of choice. Human Rights have to be adopted as a strategy for health. It was said that denial of human rights will cause ill-health as witnessed today among women, children, minority groups, indigenous people, etc. Poverty, the biggest killer today, is a violation of human rights. The speakers were: Ms. Julia Hausermann, Dr. Gudjon Magnusson, Dr. Philip Alston, and Mr. S.S. Fluss.

C. THE EFFECTS OF GLOBALIZATION ON HEALTH (MAY 1998)

In today's symposium we are going to look at what globalization is, and what effects it has on health. We have four excellent speakers who will present a global perspective, a perspective from the North, a perspective from the South and a case study to show how one organization is dealing with it. This is an issue which is going to gain prominence and will be debated. We, therefore, need to study carefully its implication on health and for each of our organizations. The speakers are: Dr. Derek Yach, Prof. Giovanni Berlinguer, Prof. David Sanders and Dr. José Tiongco, Dr. Elizabeth Bowen (Rapporteur), jointly chaired by Renate Bloem and Eric Ram.

III. Global Health Watch

One of the major initiatives of the Forum is to promote, and eventually establish, an independent, credible monitoring entity — Global Health Watch. The idea first emerged in our NGO meeting in February 1997. We put this forward during WHO's formal consultation with NGOs in May 1997 in Geneva. We discussed it in our Forum meeting last year and brought it to the notice of WHA and WHO/EB in 1997.

A Task Force of NGOs, a subcommittee of the Coordinating Committee of the Forum has been formed. The Task Force has done further thinking and developed a concept paper, which has been discussed and endorsed by the Co-Co/Forum (Available upon request).

Because of the serious nature of this entity, it is felt that proper ground work needs to be done, clarifying various aspects of the issues involved before launching it. It is for this reason the Co-Co has recommended that a stakeholders' meeting be held, in the second half of 1998, bringing together various organizations involved in various Watches, NGOs, potential donors, WHO, UNICEF, etc.

In order to make such a meeting possible, currently we are in the process of raising funds, to hire an independent consultant, who will assist us in this process.

So far, the feedback we have received is in favour of the GHW and is very positive. It is seen as an idea, whose time has come. We encourage all NGOs to support and promote the idea of GHW and, at the same time, make financial contribution toward this process. We see this as an essential element in the achievement of the HFA goal.

IV. Stakeholders Membership Fee:

So far this Forum, and before it the NGO Group on PHC, has neither established a secretariat nor a fee system.

We still remain opposed to the idea of forming a paid secretariat, meaning we all do our parts strictly on voluntary basis. However, there are numerous small costs involved in the proper functioning of the Forum such as sending out notices, papers, postage and mailings, typing and printing of notices, and reports, teas and coffees during meetings, outside speakers for various symposia, need to provide simultaneous interpretation (at times when needed), etc. They all add up to a considerable amount of money and there is no other resource than what we will contribute.

It is for these reasons the Co-Co has discussed and recommended to establish a system of collecting some financial resources to meet these needs. We are, therefore, inviting all NGOs who wish to remain a part of this growing and influential network of NGOs to both benefit from and contribute to the work of the NGO Forum for Health, by making a contribution and pledging financial support by marking one of the four categories. There is a lower limit, CHF. 150. — per year, but no upper limit.

We are an inclusive Forum of multi-sectoral NGOs and count on you to share the costs and not be dependent on others for the support of our needs.

IFCR (Dr. Ali Mahallati) is the Treasurer of the Forum and will be responsible for collecting contributions, maintaining the financial accounts, and reporting with proper accountability.

May I express my sincere thanks to all the members of the Co-Co, including WHO/Drs. Roberta Ritson, Derek Yach, and Peter Iversen who have generously provided support in various ways to the smooth running of the Forum; and to all of you for your support and indeed your commitment to achieving the goal of HFA.

Eric Ram, Ph.D.
Chairman

NGOs' Role in the Development of the Framework on Tobacco Control

Report of a Symposium and Annual General Meeting of the NGO Forum for Health
17 May 1999 • Palais des Nations, Geneva
Co-Sponsored by the NGO Forum for Health, Life University, and the Tobacco Free Initiative/WHO

NGO Forum for Health Opening Plenary
Welcome and Introduction
Dr. Eric Ram, Chair

Friends, Ladies, and Gentlemen:
It is a great pleasure for me to welcome each and every one of you to our Annual General Meeting as well as the Symposium today and the workshop tomorrow. I especially want to welcome our colleagues who have traveled long distances for these events as well as our many speakers who have come from long distances to share with us their knowledge and experiences. This is your Forum and I want you all to feel at home and contribute to the richness of the discussion extensively. You are in for a big treat today and tomorrow, as we will get to hear from world-class speakers as well as have the opportunity to contribute to the discussions.

This year's Symposium is on "The Role of the NGOs in the Development of the Framework Convention on Tobacco Control (FCTC)" and is co-sponsored by the WHO's Programme on Tobacco Free Initiative (TFI) and Life University. Dr. Derek Yach, the Programme Manager of TFI will speak to us. He and Dr. Roberta Ritson, also from WHO, have been members of the NGO Forum's Coordinating Committee for the past three years. We are happy to have Dr. Sid Williams, President of Life University, which is a benefactor-member of the Forum. He will add a few words of welcome soon.

Many of us have participated over the weekend in the meetings organized by INGCAT and the WHO as well as in WHO's technical briefings today. We have heard and seen statistics on the harmful effects of tobacco on human health, environment, and the economy. They are staggering.

A number of us NGOs have been actively involved over several years in the fight against tobacco. WHO has reinvigorated its effort through its Tobacco Free Initiative under the leadership of Dr. Derek Yach and his fine team. Together we can make a difference.

All NGOs, large and small, from all sectors of society, with our diverse mandates and activities, can take part in this effort. We all have important roles to play in this and, in fact, we can help reverse the trend. As we, the NGOs, explore ways with WHO in developing the Framework Convention on Tobacco Control, let us go all the way as we have done with other issues such as land mines.

Let us go for a total ban on tobacco production, manufacture, marketing, transportation, sale, and use. Ban its advertising, storage, export, and import. Ban sponsorship by tobacco industries of sports, meetings, and conferences. Ban donation and distribution of samples of tobacco products.

We want a total ban on dumping of tobacco products in the developing countries. Already, 70 percent of deaths due to tobacco are in developing countries, and this percentage will grow.

We want major resources to be made available to developing countries to help them fight this battle against tobacco.

We want our children and grandchildren and especially all girls and women to be safe from the disastrous effects of tobacco and to be tobacco-free.

We need more research on the prevalence of tobacco use and its effects on children.

There are many ways in which we can all work. This is what we are going to explore today.

I want to give thanks to Dr. Derek Yach and Dr. Doug Bettcher of WHO, Chitra Subramaniam of TFI, and Karen Slama of INGCAT, who have helped the Forum in finding our excellent speakers.

I also want to thank Dr. Elizabeth Bowen, who represents Health for Humanity and the Baha'i International Community. This is the third year she has served as our Rapporteur.

At this time, I want to welcome Dr. Sid Williams, the President of Life University, based in Atlanta, Georgia, U.S.A. Life University is a benefactor-member of the NGO Forum for Health and is a co-sponsor of our annual symposium today.

The topic of our symposium is "NGOs' Role in the Development of the Framework Convention on Tobacco Control."

NGO FORUM FOR HEALTH: WORDS OF WELCOME

Dr. Sid E. Williams,
Founder and President of Life University,
Atlanta, Georgia

Mr. Chairman, Honorable Director-General Dr. Brundtland, delegates to the World Health Assembly, and distinguished guests:

It is with great respect and honor that I address this gathering of world health leaders today. I consider it a privilege to have this opportunity to speak on the importance and urgency of the task facing us in finding the courage and compassion to take a unified message to all corners of the world concerning the enormous dangers of tobacco use. We must be determined to accept this huge challenge.

I grew up in a small town on the outskirts of metropolitan Atlanta, Georgia, where growing tobacco has long been a part of the culture and economy. While the evil of tobacco usage is clearly affecting human health, it must be realized that the growing of tobacco has a serious economic impact on millions of families worldwide who work directly or indirectly with the tobacco industry.

Governments with subsidies have long coexisted with family farms and more recently the agribusiness corporations. Today, governments find themselves at a crossroad where they must make serious choices and develop transitional alternatives for tobacco farmers. They must be sensitive and accommodating to the hardships that are sure to fall on many farming families and communities.

I am here to join with you, individually and collectively, to do our part and to equip others to do theirs. This initiative begins with each of us at home, in our communities, in our businesses, and in our countries.

People who use tobacco usually say they like it, and of course they do. Advertisers tell them it will give them a more acceptable image, or help them lose weight. What they don't tell them is that smoking is addictive, and that most people smoke because of loneliness, because of stress, and the strain of poverty. The addiction to tobacco use is unfortunately universal, and the reason for its use does not discriminate from country to country.

But we do know that the tobacco-related diseases are, to a very large extent, preventable. In Thailand, where 5 percent of all women smoked at the height of consumption, that figure dropped to 4.1 percent in 1986 and to 2.5 percent in 1996, despite population increases. Some of these successes are credited to policies prohibiting advertising and marketing directly to women. But it is a continual struggle against the annual $400 billion gargantuan tobacco industry.

You may recall the Biblical account of David, the shepherd boy who confronted Goliath, the giant enemy of his people, with only a few stones and a slingshot. We stand today, together, as one seemingly small band of advocates of health, and in our pockets we, too, have only a handful of resources.

First, we have unity — one mind, one cause.

Second, we have the Tobacco Free Initiative advocated by WHO.

Third, we have our own personal commitment, drive, and enthusiasm.

And finally, we have what David had: the confidence that what we do here today will be significant, powerful, and enduring.

I am confident that this Trans-National Framework Convention on Tobacco Control will provide the pivotal global leadership for the countries of the United Nations.

At Life University, our goal is to train the finest and most professional Doctors of Chiropractic and make them ambassadors of wellness and health maintenance. We teach our doctors to emphasize that health is not the absence of disease but the full expression of life. We also teach them to diagnose and correct spinal misalignments that compromise neurological and cellular functions. We encourage our students to educate the public to take responsibility for their own health by utilizing spinal hygiene measures that improve structural integrity, remove

nerve interference, and facilitate general health, and well being.
Just as dental hygiene improved the oral health of millions in developed countries, spinal hygiene also can improve the spinal and general health and well-being of millions, and is as simple as flossing and brushing your teeth.

We are pleased to announce that the World Health Organization has recently led the way with the inclusion of chiropractic in its family of NGO organizations.

Today, Life University has the largest Doctor of Chiropractic program in the world. We are committed to using our knowledge, resources, and wisdom to educate the public locally, nationally, and internationally about the merits of spinal hygiene that are cost-effective, long-lasting, and above all, natural.

Increasing taxes on tobacco products lowers their usage among young smokers. We should encourage governments to initiate and enforce tobacco regulations by converting those tax revenues back into smoking prevention and cessation programs, as well as promulgating legislation to restrict access to tobacco products to youth. These initiatives must continue to denounce the social acceptability of tobacco use in any form: smoking cigarettes, cigars, pipes, and of course tobacco chewing. Isn't this what we are here for? Isn't that what this meeting is all about?

Our task today may seem overwhelming, and our message all too simple. But, like many answers to some of life's most perplexing dilemmas, this one is clear. It is time for us to come together for the sake of humanity. For the love and gifts of life and health, and we must stand strong against the purveyors of tobacco, and the health tragedies it produces.

We are on the threshold of a new millennium, a time of new beginnings, a time of unequaled anticipation for a new and better world for all of us. Let us proceed forward from this place under the banner of togetherness and unity, to ensure the quality of life that our families and friends want, deserve, and need.

On behalf of Life University, my wife of forty-seven years, Dr. Nell Williams, and my fellow chiropractic colleagues and concerned citizens around the world, I thank you for being a gracious audience. I thank Dr. Eric Ram, President of the NGO Forum for Health, and Dr. Derek Yach, Director of the Tobacco Free Initiative and his staff for their time, efforts, and vision, in giving us the opportunity of this forum to do exciting, thrilling, and important things over the next few days. So welcome, and may this time be productive and blessed for all of us.

Dr. Ram's Introduction of Dr. Yach

Dr. Derek Yach will give us the global perspective on the FCTC. He is Programme Manager for WHO's Tobacco Free Initiative. His previous position was Director of the WHO's Policy Action Coordination Team (PAC/WHO). Dr. Yach is a native of South Africa and a good friend of the NGOs. For three years, he has served on the NGO Forum for Health Coordinating Committee.

A GLOBAL PERSPECTIVE ON THE TOBACCO FREE INITIATIVE

Dr. Derek Yach, Programme Manager,
The Tobacco Free Initiative of WHO

Thank you all very much. First, a personal comment. This is my fourth World Health Assembly. When I arrived to work on Health For All, I was fortunate enough to meet Dr. Roberta Ritson. She said to me, "If you want this to work, you better make contact with the NGO community here in Geneva." So very soon I was invited to meet with the likes of Eric Ram, Renate Bloem, Gianni Ballerio, and others in this room, and I must say, in the past few years, we have tried to work together in doing things in a very different way.

So I don't think there was any question that when WHO began the Tobacco Free Initiative, we recognized we needed to have the widest constituencies of NGOs who could reach back to countries and communities at the grassroots level where people could see the direct impact of tobacco in a practical way. We had to build upon the linkages already given to tackle such a huge public health problem. This includes the areas of women and women's rights, children and their health and development in general, human rights and the whole machinery of human rights instruments, the environment, those involved with a broad range of religions and their contributions, professional groups and organizations, as well as different representative bodies of industry. We have begun to work with the whole range of NGOs and other groups, and we have begun to see the power of people working together.

Four million deaths per year are difficult to imagine. To try to convey the magnitude of this problem, I could translate the numbers of deaths into jumbo jet

crashes. Suffice it to say that I doubt there is anyone in this room who does not know someone, a family member or close friend, who has died of a tobacco-related disease. It is difficult to think of any other public health problem where that would be the case. Tomorrow we will deal with the economic, agricultural, and environmental dimensions. I would rather spend a few moments on the aspect that the international community is perhaps least aware of, that is, the truth.

What we share is a deep concern for revealing the truth. I think it was Judge Brandeis who said, "Sunshine is the best antiseptic." Our sunshine has been the 35 million documents that have come out of the Minnesota court case that are now revealing to the world the truth about the tobacco industry.

It is a tale of deception, a tale of distortion of the facts, a tale of attempts to influence the World Health Organization. Those sound like strong words, and strong words need to be backed by facts. So let's back them. What do we now know about the science of addiction, of the science of the way the tobacco industry has approached cigarettes? Let's not forget that at the end of the day, it is not necessarily the chief executive officer that is ultimately the cause of death, it is the cigarette itself.

Dr. Brundtland, two weeks ago in Berlin, addressed a meeting of the International Conference of Drug Regulators, a group that had never before been addressed at all on the subject of tobacco. She spoke these words:

If you believe the industry is simply stuffing tobacco into paper tubes, not finetuning nicotine delivery, consider this quote from a senior scientist, working for a tobacco company and published recently from a long-hidden document. In 1972, he said, "The cigarette should be construed not as a product, but a package. The product is nicotine. Think of the cigarette pack as a storage container for a day's supply of nicotine. Think of the cigarette as a dispenser for a dose unit of nicotine. Think of the puff of smoke as the vehicle of nicotine." These are the tobacco industry's words from 1972.

The implications are profound. This demonstrates that the tobacco industry was manipulating nicotine long before admitting that nicotine is addictive.

When you look at a package of cigarettes — and, hopefully, not too many of you do — you will notice that there is a nicotine level printed on the pack. That level bears no resemblance to the amount of nicotine that is absorbed into your body. That is determined by a complex mix of factors, to deliver the right dose of nicotine at a certain time. The point is that the time has come to regulate the product itself.

Due to the court cases, there are thousands of documents that give evidence of the extensive studies that have been carried out on the addictive process. The chemistry of saliva becomes important if you are really concerned about absorption rates in the mouth. I'm starting with these very technical issues to show you the lengths to which the tobacco industry has gone over the years to deceive smokers and to carry out a careful scientific process to design a product that does what it must do to keep people addicted as long as possible.

We note with certainty that there are groups which may very well be here over the next few days, allegedly representing the interests of farmers. Here is a British American Tobacco (BAT) document of October 1988 that says that we must ensure that growers stick to politics and do not seek to use the global organization to gang up on manufacturers. It goes on to describe how they should set up an International Tobacco Growers Association with $200,000 being given by this Philip Morris/BAT group to get it going. As a benefit, the International Tobacco Growers Association could front for our third-world lobby activities at WHO and gain support for our multinational corporations.

In January 1989, there is an entire document in the Philip Morris data-set, available on the Web, which says, as one of the options, "Mobilize the global agro lobby." The benefits it suggests are the purity of the agro lobby, the power of the agro constituency, and its useful third-world bias. The second option is to manage the FAO lobby, and the third option is to attack WHO. Another option is to negotiate with WHO, to diffuse peripheral activity and major on real issues such as children. The tobacco industry realizes that a sole focus on children will not address the chief problems of tobacco control.

The next document comes from Philip Morris interoffice international network, 1989. It explains the Global Issues Campaign, which is to prepare a proactive program including an International Tobacco Growers Association and smokers' clubs around the world, to address the media from conferences and to approach allies in large growing nations, such as the Latin American Tobacco Council or the Minister of Health of Malawi, to question WHO's priorities.

What this means is that we have clear evidence that

a lobby has been created by manufacturers allegedly to support the needs of indigenous farmers. In tomorrow's sessions with World Bank representatives, we will see that the long-term concerns of farmers certainly require us to look at alternative forms of livelihood over the coming years as we work to reduce demand for tobacco, on the grounds that we need to avoid having an immediate or even a medium-term impact on farmers.

In today's *Wall Street Journal* we have an article entitled, "World Bank and WHO Gang Up on Big Tobacco." It says, "All in all, the World Bank is peddling nonsense. The smoker is supposedly burdened with a personality-splitting addiction." Remember, they knew about addiction, they knew how to create it, and now they are calling it "a personality-splitting addiction." "It is about to be taxed further, and the money will go to health evangelists, who will then lecture the addict. The approach should alarm those selling other so-called addictive products, such as alcohol, coffee, and chocolate."

We urge you to look at our Web site, which will lead you to many other Web sites showing which scientists have been named and have been paid to write articles along the lines of the article that appeared in today's *Wall Street Journal*. The point of mentioning this to an NGO group in particular is that often it is difficult, because of the reality of politics, to be able to be sure where the truth is coming from.

One of the roles of NGOs as representatives of civil society needs is to cut through the bureaucratic problems that obstruct governments in their often well-intentioned efforts to improve the public welfare and to support governments when they know truth is being subverted by the hypocrisy of the tobacco industry.

When I look at examples such as the tobacco industry's Global Issues Campaign, this kind of knowledge is available for every country to use in a very practical way. Through the Internet, we can start making this material available to you. In every setting where we talk about tobacco control, there will be those from the tobacco industry. I have no doubt that in this room we already have those people. I would say to those from the tobacco industry, think about the public health consequences, think about the economic realities, and examine your own conscience.

FRAMEWORK CONVENTION ON TOBACCO CONTROL: A PERSPECTIVE FROM THE NORTH

Kathryn Mulvey

Note: Ms. Mulvey is Executive Director of INFACT, a grassroots corporate watchdog organization based in the United States. INFACT's purpose is to stop life-threatening abuses of transnational corporations and increase their accountability to people around the world.

It's a great honor to be here today to speak with so many NGO colleagues about the Framework Convention on Tobacco Control. Thank you to Dr. Eric Ram for inviting INFACT and to Dr. Derek Yach for his leadership within the WHO.

I've been asked to speak from a Northern Perspective, with some consideration of major issues the FCTC should include. The perspective I'd like to present revolves around a fundamental analysis: transnational tobacco corporations (TTNs) are the contagions of a preventable global epidemic. This analysis has important implications for NGOs world-wide, namely, that effective tobacco control work must transcend national boundaries, and that the ultimate solution must be global in scope.

For those of us in the North, there is another layer. TTNs are based in our countries and chartered in our names. It is therefore our responsibility to hold them accountable. The export of addiction, disease, and death — with the consequences predicted by the World Health Organization — is a form of toxic trade. In the absence of organized resistance, it will continue to exacerbate the resource imbalance between North and South.

So what and who are these corporations? As a U.S.-based organization, INFACT has focused its attention on the two leading U.S.-based TTNs, Philip Morris and RJR Nabisco. They provide an illustration of the size, sphere of influence, and global reach of the TTNs.

Philip Morris, the world's largest tobacco corporation, had $58 billion in revenues last year. It rode to the top on the strength of Marlboro, the leading worldwide cigarette brand and the number one choice among kids in the U.S. The Marlboro Man, according to an advertising executive who helped create the campaign, was designed as "the right image to capture the youth market's fancy — a perfect symbol of independence and individualistic rebellion." Marlboro is also the engine of Philip

Morris international expansion; the corporation's operating profits from international tobacco have increased by 261 percent since 1990.

At the same time, 47 percent of Philip Morris revenues and 37 percent of operating profits come from Kraft Foods. Based on food sales alone, including international cheese, coffee, and confectionery, under brands such as Kraft, Maxwell House, and Jacob Suchard, Philip Morris would be one of a handful of the world's largest food corporations.

As for RJR Nabisco, prior to the recent sale of its international tobacco business, it was a $17-billion corporation and the world's third largest TTN. This sale, followed by the announced spin-off of domestic tobacco from Nabisco Foods, demonstrates the power of consumers, shareholders, and litigators to change the business climate around a corporation. RJR acquired Nabisco in the mid-1980's as a cover for its tobacco abuses, just as Philip Morris acquired Kraft and General Foods. The tobacco corporations were seeking to boost their image, constituency, and credibility, for example, with politicians and the broadcast media. But RJR was forced to abandon its strategy, facing pressure from activist shareholders calling for a spin-off and from INFACT's grassroots boycott.

So we are dealing with powerful economic interests. While the goals of NGOs, international governments, and WHO focus on public health, these TTNs are motivated by profit, and accountable only to shareholders. The profit motive is a critically important variable because these corporations will invest a portion of their vast resources in the short term to protect what they see as their long-term interests.

International corporate documents released through the Minnesota trial provided the "smoking gun" about what TTNs knew and when they knew it. They also offer a rare window into the inner workings of these giant transnational corporations. As we strategize around the FCTC, NGOs would do well to incorporate these lessons into our planning.

The Philip Morris documents in particular lay bare the gulf between internal operations and external posture of the TTNs. While they feign indifference to advocates' actions, they actually are spending significant time and money investigating and monitoring us, directly or through public relations firms such as Burson-Marsteller. These public relations firms also advise them on developing a comprehensive strategic response to tobacco-control initiatives, including communication from and to all levels and divisions of the corporation. This response is well choreographed, and representatives well-trained in delivering the message, so as to create the illusion of spontaneity and independence.

The TTNs are well-aware that their own credibility is lacking, so they hide behind subsidiaries, allies, and front groups. We should expect opposition to the FCTC from Kraft and other retailers, advertisers, the media, farmers, and trade associations representing all of these interests. NGOs must be prepared to expose and neutralize phony "grassroots" organizations such as the National Smokers Alliance in the United States.

The FCTC will be a political as well as a legal document. The substantive issues that we highlight for attention must both address the practices that promote the spread of tobacco addiction and strategically frame the political context. In 1993-1994, INFACT, in consultation with dozens of allies from all over the world, initiated a similar analysis and consultation process in developing our Public Challenge to the Tobacco Industry. I'd like to review the major points of this challenge as they relate to the content of the FCTC.

NGOs can play a key role by creating a public and political climate that demands action by WHO and governments to stop tobacco marketing and promotion that appeals to children and young people.

The TTNs' key expansion market is youth. Virtually all new smokers start by age 18. With an addictive product, an early start usually means a lifelong customer.

Based on these market realities, the TTNs have positioned the cigarette as a rite of passage from childhood to adulthood. An effective FCTC should prevent industry access to the youth audience. For NGOs, framing the issue around children appeals to a wide pool of potential supporters: parents, politicians, smokers, and nonsmokers, alike. At the same time, the burden of proof must shift to the TTNs to show that their marketing does not appeal to children. We are interested in *effect, not intent*.

For the FCTC to be a flexible, living document, advertising and promotion must be defined as broadly as possible to mean all paid promotion of tobacco products, brand names, logos, and colors. The FCTC has a particular role to play in dealing with transnational advertising such as the Internet and broadcast of sponsored events, but should also provide a model for states to avoid loopholes in advertising restrictions. As TTNs shift from direct

advertising on billboards, radio and television to sponsorship, brand-stretching and other tactics we may not yet envision, the FCTC can establish both the letter and the spirit of the law at a global level, to help the public and policy-makers see through, and ultimately reject, industry evasion tactics.

Global aggression: Stop spreading tobacco addiction internationally
The TTNs are the driving force behind the expansion of smoking prevalence and consumption, introducing new marketing tactics that force other companies to compete and breaking into new markets through covert or overt support of smuggling. NGOs from the North have a particular obligation to block this toxic trade, on economic, social, cultural, and human rights grounds.

Economically, the transfer of local assets to transnational interests is this Century's form of imperialism, and it weakens the internal capacity of states to manage tobacco control and other public health policies. Socially and culturally, we have several reasons for outrage. One is the dissemination of a simplistic, false image of Northern, and especially U.S., culture; second is that this image is being manipulated to promote the sale of a deadly product; and the third is that cultures are being drowned out, abandoned, and lost to the world in the face of this dominance.

On the human rights front, the FCTC can take a stand for meaningful women's equality. That less than five percent of women smoke in many economically poor countries is a social value that should be preserved. Allowing the TTNs to claim the mantle of women's rights is worse than trivializing the matter; it potentially undermines genuine equity by making women skeptical of the whole concept. NGOs have a vested interest in retaining or reclaiming women's rights.

Stop influence over, and interference in, public policy on issues of tobacco and health
This challenge can inform both process and content for the FCTC. The TTNs' ability to get away with outrageous marketing practices is rooted in their ability to control public policy making and implementation. Involving TTNs in development of tobacco control legislation has often resulted in policies that do more harm than good, for example, by creating the impression that the problem has been solved or by pre-empting additional action. NGOs can expose TTN interference in the FCTC, with attention to the allies and front groups mentioned previously. The WHO must also be vigilant in ensuring that the FCTC does not veer off course from its public health objectives.

As a compliance mechanism, the FCTC can restrict future TTN involvement in national and international policy making. This might include restrictions on political contributions, closure of national tobacco institutes and other trade associations, disclosure of lobbying activities and expenditures by the TTNs and their affiliates, and limiting tobacco industry access to the courts on matters related to public health policy.

Stop deceiving people about the dangers of tobacco
Another source of the TTNs' power has been their constant denial of nicotine's addictive nature and tobacco's deadly effects. The evidence from the Minnesota trial gave the lie to many of the industry's traditional denials. The FCTC could make the most of these revelations by codifying them as prohibitions to certain judicial defenses and disputes by the tobacco industry. The urgency of the epidemic demands that NGOs and governments ensure maximum access to and application of this information. Refusal to tolerate TTNs' lies will end a strong message to other industries as well.

Pay the highest costs of medical care associated with the tobacco epidemic
The principle of "the polluter pays" must apply to the tobacco industry. Profit margins on this deadly product have been so high because the TTNs have privatized profits while socializing the costs. As the U.S. begins to recover some of the costs of treating people addicted to cigarettes, NGOs and governments in the North have a duty to ensure that these payments do not simply come from increased sales in other regions. The FCTC can establish "the polluter pays" principle, ensure that countries get their fair share, and prevent the economic burden from falling disproportionately on poor countries.

Economic conversion is a related issue. Just as in the wake of the Cold War, military economies have been forced to shift to more peaceful production, so we must engineer a changeover from tobacco manufacture to more socially valuable production, with responsibility and assistance from TTNs. From small farmers shifting to alternative crops to governments and other organizations seeking replacement revenue, to stem this epidemic we must stop not only the physical, human addiction but also economic addiction to this product.

Over the past several years, we in the United States have made some important progress. Through litigation, TTNs are finally bearing some of the costs of caring for those addicted to tobacco. Faced with public pressure and exposure, these corporations have abandoned a few of their more blatant youth-oriented tactics, such as billboards and Joe Camel.

It is also significant that TTNs have been forced to change their corporate posture. Having formerly secret documents on the public record will make it more difficult for these corporations to get away with lying in the U.S. and internationally. Over the past year, Philip Morris has also gone on record with altered positions on youth marketing in the U.S. and abroad. For years Philip Morris defended double standards between U.S. and international practices on the grounds of national sovereignty and respect for cultural diversity. Then last year, just weeks after Mary Assunta was the first health advocate from an international "target market" to speak on the floor of the Philip Morris annual meeting, the CEO told employees: "We will align our marketing practices in the USA and overseas so that we cannot be accused of marketing cigarettes to youth."

In the U.S., Philip Morris has suddenly committed $100 million to its version of youth smoking prevention. The new senior vice-president in charge of the program says, "We recognize that success in youth smoking prevention efforts ... could lead to a smaller adult consumer base in the future. So be it."

Of course, there's no reason to give Philip Morris the benefit of the doubt. Our charge is to lock those statements in, ensure that they're translated into actions and results, monitor follow-through, and institutionalize the gains through regulatory action at all levels. One role for NGOs is to keep a watchful eye on TTNs and governments. The NGO community has gained valuable experience from other international codes and conventions, for example, on breast milk substitutes, land mines, and environmental issues such as ozone depletion and climate change.

Lessons from the Land Mine Campaign include the importance of establishing regular communication between NGOs, particularly between the North and South. The need for NGOs to establish common goals and principles, and stick to them, was also emphasized by NGOs active in this process and also on the tobacco issue. Identifying government allies is key. The challenge of achieving consensus within the UN process eventually led governments, with Canada in the lead, to take the treaty out of the traditional process, which dramatically sped up its adoption. NGOs worked very closely with governments, in an unprecedented manner, to ensure successful ratification of the treaty in 1997.

Some of the important lessons from the Baby Food Campaign for NGOs working on the FCTC include the importance of developing international networks or coalitions. These networks can share information; create strategies; expose ongoing industry abuses to the media, governmental delegates, and the WHO; develop lobby strategies; and agree on some basic points regarding what the final outcome should be. A clear lesson that came out of the process is the importance of preventing industry involvement. INFACT and other NGOs kept up consumer pressure that created a climate that made WHO's actions in setting international standards feasible and reasonable.

Lessons from environmental conventions include the importance of NGOs to agree on some broad goals, to realize that different kinds of approaches are needed, and to establish good relationships with key countries. If NGOs are to be effective as "watch dogs," ratification and compliance cannot be forgotten.

NGOs help shape the public and political climate around tobacco control and other health issues, by agreeing on and presenting visionary goals and then creating the political imperative for action. There is a need for NGO participation from a wide range of geographic areas and constituencies, pursuing a variety of strategies based on the NGOs' strengths and expertise. Some will apply economic pressure on the TTNs, others will monitor and expose abuses by the industry and its allies, still others will lobby governments and national delegations on the FCTC.

For those of us in the North, it is a matter of reining in the Marlboro Men, who operate in our names in co-opting our culture so that people's movements in other parts of the world can assert themselves. TNCs in dangerous and deadly businesses have sought to manipulate international institutions to their own advantage. Through trade regimes such as NAFTA, MAI, and the WTO, TNCs have lobbied for the lowest common denominator, pre-empting national action at the international level as they have pre-empted sub-national action at the national level.

WHO, with the support of NGOs, can make the FCTC a floor rather than a ceiling. This would be a tremendous assault on the tobacco epidemic, and it would set dramatic precedents for holding super powers accountable when they threaten health and the environment.

INTERNATIONAL FRAMEWORK CONVENTION ON TOBACCO CONTROL: A PERSPECTIVE FROM THE SOUTH

Mary Assunta

Ms. Assunta works as a media officer with the Consumers Association of Penang, Malaysia. She has coordinated several major health campaigns.

Introduction

The vast majority of smokers are from developing countries, that is 800 million out of the 1.1 billion smokers. The decrease in consumption in the U.S. and Western Europe has resulted in tobacco transnational corporations turning to the developing world to make up for the loss of their markets. While per capita consumption of tobacco fell by 10 percent between 1970 and 1990 in developed countries, it increased 64 percent in developing countries in the same period. Per-capita consumption has more than doubled in Haiti, Indonesia, Nepal, Senegal, and Syria, while it has tripled in Cameroon and China.[1] Asia is the fastest growing market in the world with China having some 300 million smokers. The bulk of the carnage in the future will occur in developing countries, some 7 million deaths a year in the 2020s.

Developing countries offer huge market potentials. The combined population of Africa, Asia, Latin America, and the Caribbean is 4.87 billion, nearly five times the population of Europe and the U.S., 1.03 billion. The former chair of the BAT had once quipped, "These are exciting times I have seen in the tobacco industry in the last 40 years."[2] BAT is the largest transnational corporation operating in Asia today and derives 75 percent of its sales from developing countries.[3]

Smoking is the single most important preventable cause of death and the most important public health issue of our times. As such, the International Framework Convention on Tobacco Control is set to be the most important international tool for tobacco control in developing countries, the bulk of which do not have a comprehensive tobacco-control policy in place. With our future at stake, developing countries should be actively participating in the input and very process of the Framework Convention. I will briefly look at how to give some teeth to the Convention, the significance of the Framework Convention to developing countries, our limitations in the negotiation process, and some strategies.

[1] Human Development Report, 1998, UNDP
[2] "Marketing of Tobacco Products: the North-South Divide," by World Development Movement, September 1998
[3] Global Health & Environment Monitor, Spring 1998, Vol. 6, Issue 1

Elements We Want to See Included in the Convention

1. International trade

The Framework Convention is an important initial step for international tobacco control but it must go further if it is to have teeth. The most crucial point it must address is the trade aspect of tobacco. In order to prevent further disaster in the West, national laws are being tightened up, court cases are mounting, compensation for Medicare is being paid out, and the anti-tobacco lobby is gaining ground in the North. Unfortunately, this has resulted in cigarettes being pushed from developed countries into developing countries. In other words, tobacco control actions in the North are unfortunately resulting in killing more people in the developing countries. This is why the convention must address the international trade aspect of tobacco.

Tobacco transnationals practice scandalous marketing tactics in developing countries that they are not allowed to pursue in their home countries. They blatantly advertise, sponsor music and sports events, and give away free cigarettes to teenagers. The women in gold saris handing out Benson & Hedges cigarettes in Sri Lanka's discos, young women dressed in red and white handing out free Marlboros in Cambodia, the Blessed Virgin Mary advertising cigarettes in the Philippines — these are all testimony to scandalous double standards and total disregard for human life.

In Malaysia, the transnationals circumvent our tobacco-control laws banning cigarette advertising by engaging in indirect advertising through brand name stretching. We have also become the testing ground to develop BAT's Benson & Hedges Bistro, the answer to overcoming the European Directive banning cigarette advertising adopted last year. This form of double standards, advertising, event sponsorship, and other such insidious marketing tactics in developing countries, must stop. We in the South have not been able to stop this on our own. Exceptions are Thailand and Mongolia, which have comprehensive tobacco-control programmes.

In 1964, the U.S. Surgeon General issued the first report declaring cigarettes to be a major cause of disease and death. Despite this knowledge, the U.S. government was instrumental in forcing open markets in Asia in the 1980s that were then closed to its tobacco transnationals. Japan, Korea, Taiwan, and Thailand were running their own tobacco monopolies with promotions. But after the U.S. used the Super 301 trade clause, opened these

markets, and captured the young with glitzy advertisements, the results were devastating. After the arrival of the Marlboro Man and the other American cigarettes, smoking among the young rose significantly: 16 percent in Japan, an increase from 19.5 to 32.2 percent in Taiwan, and an increase of 24 percent among the Thai teenage smokers.[4]

Hence it is vital that the Convention addresses the international trade aspect. The WTO and unilateral trade practices should not be used to push tobacco on developing countries. Public health should take precedence over WTO's clause on market access.

The tobacco industry will be opposed to this move. The Biosafety Protocol negotiations, which collapsed in February 1999, is a good lesson. When we gained ground on the scientific/environmental/health aspects, the industry and their supporting governments went all out to use the trade argument, that is a stringent biosafety protocol would violate trade interests and WTO rules. There they tried to solve the world's hunger problems approach, but in the FCTC process, the established horrors of tobacco consumption puts us on a stronger starting point. WTO rules allow exceptions to free trade on health and public morality grounds.

2. Ban export of tobacco from OECD to non-OECD countries

Many tobacco-control advocates are already looking into the classification of nicotine as an addictive drug. Cigarettes are the only consumer product that kills when used exactly as intended by the manufacturer. Cigarettes are hazardous and contain about 4,000 chemical compounds, vapors, and poisons. Nicotine is as addictive as heroin and cocaine. Besides merely classifying nicotine as an addictive drug, this status must be given an international standing to make it meaningful for us in the South. Borrowing from the Basle Convention banning the export of hazardous waste across borders, the export of tobacco, a hazardous product, should be regulated. We propose a ban on the export of tobacco from OECD countries into non-OECD countries.

3. Export only possible with prior written consent

If we are unable to ban the export of tobacco from OECD countries to non-OECD countries, then the next best thing we propose is that no country should be allowed to export tobacco unless it is furnished with prior written consent from the importing country. Developing countries should have the right not to import tobacco if they so choose and developed countries should not take acceptance. The exporting country must also furnish to the purchasing country all knowledge and information about the product. At the moment, the cigarette is probably the only consumer product that does not provide an ingredient listing, and transnationals sell more poisonous cigarettes to smokers in developing countries.

4. Liability by manufacturers for adverse effects

The U.S. deal with the tobacco transnationals needs to be considered in the FCTC since these companies also operate across the globe. In some countries they have a monopoly over the business through its local subsidiary, such as BAT in Sri Lanka. The U.S. transnationals have remained silent about compensation outside the U.S. This needs to be seriously considered, and liability by manufacturers for adverse effects such as disease and death must be met.

5. Phasing out tobacco cultivation

Developing countries, which are tobacco producers and cigarette manufacturers, will also be pushed by those domestic interests to reject a strong and comprehensive Framework Convention. However, if the Framework Convention has an objective in reducing tobacco production and consumption in every country, we have a stronger argument that the Framework Convention is a powerful public health tool that can build the necessary steps for countries to shift away from such as unsustainable means of production and consumption. By dealing with the environment, social, and economic effects of tobacco cultivation, the Framework Convention would make a strong case for a phase-out of the industry in developing countries, most of which have a small cultivation/production capacity.

6. High taxes on tobacco and high prices for cigarettes

In many developing countries cigarette prices are kept low by the industry so that they are affordable to the young and poor. Children are most responsive to price increases and high prices is an effective way to reduce accessibility. There must also be a regional agreement over pricing to address the smuggling problem. Tobacco companies fight tax increase by citing increase in smuggling. In recent times, tobacco executives themselves, of RJ Reynolds and BAT, were found to be involved in this international crime. Companies must be made to post a bond that can be returned when cigarettes reach their final

[4] "America's New Merchants of Death," by William Ecenbarger, **Readers Digest**, April 1993.

destination. Manufacturers, distributors, and retailers should be licensed and made to keep detailed records. Funding for tobacco control activities is a long-standing problem with developing countries. A dedicated tax is one way to fund tobacco control activities, as proven to be effectively done in Australia.

How Will the FCTC Help Us?

1. The FCTC will strengthen tobacco control measures in the South, which are now generally weak. In many developing countries, laws on tobacco control are piecemeal; some of these are weak and riddled with loopholes which the tobacco industry exploits. In still other countries, they are non existent.

2. The FCTC will set standards for countries to abide by and bring all member governments on par in terms of tobacco control. One example of disparity is about 30 industrialized countries in total now have, or are bringing in, comprehensive tobacco marketing restrictions, compared to only about eight developing countries.

3. The FCTC will stop the double standards and halt once and for all the blatant marketing practices of the tobacco transnationals across the globe. There is a predictable pattern in the way the tobacco transnationals deal with governments, always starting with code of advertising practice in the place of legislation, not showing the person smoking, to removing the person from the advertisement to showing just the pack, and so on. Today, we see India going through the processes Malaysia did in the 1980s.

4. The FCTC will provide the necessary impetus to governments in the South to have a policy on tobacco. This is especially for those that have been dragging their feet over implementing comprehensive tobacco policies and legislation, and actively protecting the industry.

Our Limitations

1. Lack of publicity on the FCTC

While the Framework Convention has generated a fair amount of discussion and mention at international forums, it has not received much publicity in countries in the South. WHO has worked out a possible time frame referred to as a "broad template" for an FCTC-accelerated work plan from September 1998 to May 2003, when the FCTC is expected to be adopted. By June this year, the technical consultation is scheduled to be completed, according to the Convention's accelerated plan. NGO tobacco control advocates from Thailand, Pakistan, and Bangladesh have informed me that there has been no active discussion or much publicity on the Convention at the local or national level in these countries.

This is worrisome, especially if developing countries are to be actively involved, and if time is of the essence here. The outcome of the FCTC is significant to us in the South, where the future markets are, and we need to redeem the time. The Thai experience in fighting the invasion of U.S. cigarettes, subsequently drawing up one of the most comprehensive legislations in the region and now warding off efforts to denationalize their tobacco monopoly under the IMF economic bailout package, can be valuable to us in the South. The Thais should be actively involved in the FCTC process.

2. Lack of resources

The biggest obstacle the tobacco control advocates from the South face is the lack of resources, as in lack of funds and experienced personnel to do the job, lack of time, and lack of information (about FCTC and knowledge of international law). We need these resources if we are to actively participate in the FCTC process.

3. Participation in negotiations

If other conventions are a basis for reference, developing countries usually have small delegations, often only one person. It would be impossible for these countries to participate fully in negotiations. If a few tracks are held at the same time, we can't be present in all meetings. If they are scheduled for different times of the year, the person concerned will find it very difficult to be traveling so often.

Some Strategies

1. Solidarity

Solidarity among developing countries is vital. Even if consensus is not reached among the Group of 77 countries, those who want a strong Framework Convention can get together and maintain a common strong stand. In the Biosafety Protocol negotiations, a "Like-Minded Group" comprising all developing countries including China was formed when Argentina, Chile, and Uruguay joined the U.S., Canada, and Australia to block the protocol.

2. NGO-Government link-up

We need to identify officials who attend the WHO meetings — negotiators who have a history of the negotiations/debates leading up to the 1996 Resolution for the Framework Convention. For NGOs in the South, we need to make good contacts with our government delegates and provide them with lots of input. It would be crucial for Northern NGOs to put pressure on opposers and forge strong links with supporters within their governments. In the U.S. there are some senators who have voiced concerns that the U.S. industry deal will result in market access pressure in developing countries. They would be good allies to have so that the U.S. Administration's negotiating position will be open to Senate and public scrutiny. Having some pro-tobacco-control legislators/Parliamentarians follow the negotiations may be a good idea.

3. NGO observer status in negotiations

NGO observer status in negotiations must be ensured because there may be opportunities to make statements and contribute to discussion in open negotiating groups. NGOs should work on elements and modalities (i.e. ways and means to operationalize the agreement) of the Framework Convention on Tobacco Control. This document could be used for lobbying governments and for getting more public support.

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COUGHING UP PROFITS IN AFRICA

Yussuf Saloojee, Ph.D., Executive Director, National Council Against Smoking

In January 1999, British American Tobacco (BAT) and the Rothmans International Group announced a $25-billion merger. Asked why he gave up control of Rothmans for a minority share-holding in BAT, South African tobacco baron John Rupert philosophically replied: "Don't eat at a place called Mom's, don't argue with people who buy ink by the gallon, and don't put saving face before facing facts."

So what are the facts of the tobacco business? According to the South African newspaper *Business Day*, "Growth in tobacco consumption is now focused in the developing world. It is an unpalatable fact that growth in this industry will take place where governments are least hostile and where populations are not educated about the harmful effects of smoking."

It added: "What neither company stated openly, but what they both hinted at, was that their combined geographical spread would give them the edge, in what was essentially a two-horse race in the fight to win new smokers in developing markets."

A BAT spokesperson has admitted that the new multinational is expected to target the growing markets in China, Africa, India, and the Far East. The merger will increase the profits of BAT, but what of the other side of the coin? Put simply, increased sales of cigarettes means increased deaths. This presentation examines the choices that have been made in Africa about tobacco, what choices are likely to be made in the future, and why it matters.

Tobacco Use in Africa

The African region has the lowest rates of tobacco consumption in the world. In 1963, it is estimated that just under 400 cigarettes per adult were sold; by 1990 that had risen to about 580. This compares to a 1990-1992 global average of about 1,660.

There are, of course, large variations in tobacco usage from country to country. In 1990-1992, consumption was highest in Mauritius (1,830 cigarettes per adult), Tunisia (1,750), and South Africa (1,720). It was lowest in Niger (170), Sudan (150), and Ethiopia (90).

Smoking rates are low because people basically cannot afford to buy cigarettes. Smoking is even lower among women because they have even less disposable income than men and because of social and cultural proscriptions.

Tobacco Mortality in Africa

The low smoking rates mean that Africa is the only WHO region in which primary prevention of the unfolding global tobacco epidemic is possible. The World Development Report (1993) estimates that in 1990, about two million of the eight million deaths in Africa occurred after the age of 30, and that about 90,000 of these deaths could be attributed to smoking. In contrast to some developing countries where tobacco causes one in every five or six deaths, in Africa it causes about one in every 84 of all deaths and one in 20 of adult deaths.

As a result of the relatively low death rate, tobacco control is not a priority in most African countries. By 1993, fewer than 30 percent of governments in sub-Saharan Africa had introduced any tobacco control legislation. For most countries, economic

development, job creation, housing, AIDS, and other communicable diseases are a higher and more urgent priority.

Indeed, Martin Broughton, CEO of BAT, has argued that in developing countries, "To put it bluntly, people don't live long enough to worry about cancer." Some African Health Ministers have echoed this sentiment by querying, "Why tobacco?" when asked to support tobacco control measures. A trade unionist working in the tobacco industry frankly told me: "I would rather die from cancer than from poverty."

My response to the trade unionist was: "Africa does not have a choice between poverty and cancer. If present smoking trends continue, we will suffer the worst of both worlds: diseases of poverty compounded by diseases of lifestyle."

To get a glimpse of Africa's future in the absence of strong preventive tobacco-control measures, one has only to look at the Western Cape Region of South Africa. There is a high prevalence of smoking among both men and women in some communities, and lung cancer rates are escalating while at the same time tuberculosis and childhood diseases remain major killers. Between 1966 and 1988, lung cancer deaths increased 100 percent among men and 300 percent among women.

Tobacco control is also about the priority one gives to prevention. The time bomb of disease is ticking away. If African countries follow the same trend as in developed countries, its tobacco epidemic can be expected to peak in the middle of the next century. Very rarely do we have the ability to predict an epidemic that far into the future and also have the knowledge to prevent it now.

Tobacco and Trade

Perhaps the greatest impediment to the implementation of tobacco-control policies in Africa is the widely held perception that tobacco provides jobs and contributes to the national economy. Tobacco's economic importance varies dramatically from country to country. In Malawi, tobacco is the backbone of the economy, with tobacco leaf exports contributing some 60 percent of Malawi's total export earnings. In Zimbabwe, too, tobacco is the main foreign currency earner, bringing in about 25 percent of export earnings. But these two countries are exceptional cases.

In 1992, out of 27 African countries for which data were available, 21 (77 percent) had a negative balance of trade in tobacco. They spent more importing tobacco than they earned exporting it. For example, Senegal, which in 1988 had a balance of payments deficit of $248 million and received 117,000 tons of cereals in food aid, paid $28 million for imported tobacco and cigarettes in 1986.

Further, tobacco growers earn only an insignificant share of the total profits made from tobacco. It is the manufacturers who obtain the lion's share of the profits. The large multinational manufacturers purchase 85 to 95 percent of the tobacco exported from the developing world, and it is they who set the price for tobacco. The growers are at the margins of the process.

Last year, leaf prices slumped across all African markets, and in Zimbabwe prices fell by as much as 40 percent. At one stage, this resulted in delays in opening markets in Malawi, auction closures in Zimbabwe, and protracted negotiations in Tanzania. Even the International Tobacco Growers Association that usually echoes the manufacturers' positions was moved to complain. Richard Tate, its chairman, said: "By switching prices on and off in successive seasons, the buyers are endangering long-term stability of supply … We have all been surprised at the buyers' short-sighted behavior, which has severely affected all the regional markets."

There are two policy directions for countries suffering a negative balance of trade in tobacco. The first is to become self-sufficient in tobacco production. The second is to introduce tobacco-control policies that will both reduce the demand for tobacco imports and long-term tobacco-caused health problems.

What Should Be Done?

The second path is the preferred option on the road to sustainable economic development. However, while the tobacco industry is moving into the developing world, the overwhelming focus and resource allocation of research, lobbying, and action on tobacco control remain firmly centered in industrialized countries.

Despite this pattern, even in many low resource environments there is an emerging capacity for tobacco control. With little more than determination and a belief in health, the first pan-African organization, The Tobacco Control Commission for Africa, was established in 1994. Its purpose is to:

- Build a sustainable human and institutional

capacity for tobacco control in Africa;
- Promote national and regional strategies for reducing tobacco use; and
- Foster research to measure tobacco use and its health, economic, and environmental impact.

In conclusion, cancer is a disease that knows no geographical boundaries. Therefore, we should aim at nothing less than a global coalition to control tobacco. We inadvertently provide support to the tobacco companies by confronting them in one country at a time. It is time to mount simultaneous action in every country, as is proposed by the international Framework Convention for Tobacco Control. If they have to spread their resources, their legal teams, their professional consultants, and their efforts to 100 countries at a time, they are going to lose more encounters. And when they lose, health wins.

FRAMEWORK CONVENTION FOR TOBACCO CONTROL: A PERSPECTIVE FROM THE INDIAN SUBCONTINENT

Dr. Thelma Narayan
Society for Community
Health Awareness, Bangalore

Introduction

The spirit of voluntarism and of doing work for the common good, with a sense of non-attachment or detachment, is deeply embedded in the social fabric of the Indian sub-continent. Voluntary organizations and agencies have been active in India since the 19th Century. Currently, many non-governmental organizations (NGOs) or voluntary agencies (a preferred term) are active throughout India. They engage in diverse fields from service delivery of medical care and comprehensive community health, to education, income generation, development, legal aid, gender issues, formation and support of peoples' organizations, and other types of social action.

Tobacco-control work at a larger policy level was initiated by the voluntary sector in the 1980s. The Voluntary Health Association of India (VHAI), a national federation of more than 20 state voluntary health associations with more than 3,000 members, has been active in the tobacco campaign. It was instrumental in forming the first anti-tobacco network in India which was called ACTION (Action to Combat Tobacco Indian Organizations Network) with its secretariat in VHAI. Some years later, the Network assumed a new name, NOTE (National Organization for Tobacco Eradication). Its headquarters is in Goa.

Several research and academic institutions and institutes of oncology have also done in-depth and sustained work for the tobacco campaign. The Tata Institute of Fundamental Research, Bombay; the Tata Memorial Cancer Centre, Bombay; the Kidwai Institute of Oncology, Bangalore, which has an anti-tobacco cell; and several others, have made notable contributions. This work includes conducting studies of different types, lobbying with central and state governments and other bodies such as the Cricket Board in India, creating awareness among health professionals and the public, publishing in NGO and professional journals, working with the media, and networking. These efforts have resulted in action such as statutory warnings on cigarette packs, increased taxation on cigarettes, and the passing of legislation including banning smoking in public places and fixing age limits for purchase of cigarettes by some states such as Goa, Maharashtra, and Delhi.

Currently, there are moves to control and even ban the sale of chewing tobacco. The Central Council of Health is discussing this issue, which is a policy body at the national level, with all state health ministers and health secretaries as members. The print media has given some coverage to the campaign and these developments. Medical institutions and practitioners also undertake preventive education and tobacco-cessation work with individuals. Group education, campaigning, and resource generation are also done by health NGOs and groups such as the Cancer Patients Aid Association.

However, on the whole, public awareness concerning tobacco-related issues is still low, efforts and actions are patchy and inadequate, and policy implementation is weak. Tobacco sales are increasing annually, especially among the young. With stronger advertising campaigns and the entry of multinational companies (MNCs), it is predicted that the magnitude of this already large public health problem will increase. There is an urgent necessity for governments, NGOs, academic and research bodies and peoples' organizations to work together at national and inter-country levels to address different dimensions of the issue. During the past few years, a series of events such as the recent court cases in the U.S.A.; the policy changes that are being introduced by the U.S.A., the European Parliament, the U.K., and other countries; and the Tobacco Free Initiative of the WHO, mandated by the World Health Assembly; offer a window of opportunity as never before to

advance the tobacco-control campaign and to initiate major policy changes that can greatly improve the health of the community. Based on sound medical evidence and on the principles of public health, the approach will also involve the legal and political control of an industry whose products are injurious to the health of the public. The transnational tobacco industry requires international mechanisms of control, and for this, the development of the Framework Convention for Tobacco Control is of crucial importance.

Reflections on the role of NGOs in developing the FCTC from a policy perspective follow. The relationship with other dimensions of tobacco-control activities that require joint action by governments, NGOs, professional bodies, and others is also considered.

The Roles of NGOs

It is useful to place the development of the FCTC and the role of NGOs within a policy perspective. This would include identifying the initiative within the socio-economic political context at national and global levels, examining the local tobacco industry and local patterns of tobacco use, identifying major groups who have a stake in supporting or opposing tobacco control, evolving processes and strategies by which policies are introduced and implemented, and improving levels of organization and methods of communication used. Technical aspects, such as studying the magnitude and distribution patterns of the health consequences of tobacco use, are crucial. Considerable work on this has already been done and study findings are the foundation for current initiatives.

- Given that tobacco MNCs are increasingly targeting markets in India, China, and East Europe due to declining Western markets, the FCTC is an important instrument for global tobacco control. NGOs can be encouraged to support the WHO initiative. Standards and controls that are applied to MNCs may be adapted and applied to national and local companies.

- Support for the development of the FCTC is only one aspect of NGOs' roles in the broader Tobacco Control Campaign. NGOs need to and can help to place and to keep tobacco control and the FCTC on the public policy agenda, as a public health, consumer, and human rights issue. We must bear in mind the need to sustain the campaign over a long period of time, as the implementation of a tobacco-control policy will necessarily take years. We therefore need to have the mindset of long distance runners.

- NGOs need to work for the FCTC and the broader tobacco campaign at local, national, and global levels and to support each other vertically and horizontally, as all levels of intervention are important. In India, functioning in a federal system, we need to work with Central Government, with state governments of 26 states, and with elected political representatives and government authorities at district levels. This is a complex task, with state governments belonging to different political parties. Neighboring countries, too, have different forms of political governance and cross-border tobacco smuggling goes on. Hence it is essential to network, share information, and build coalitions.

- The development of the FCTC as an international treaty requiring ratification by WHO member countries will need to consider the legal systems and constitutions of different nations. For years, NGOs in India have worked with academic and legal bodies on other social issues that have legal implications. National and regional working groups with representation from all sectors could support the process of developing the FCTC. NGOs may even be able to initiate such a collaboration.

- The Framework Convention, or any policy, however well thought out and articulated, is only as good as its implementation, and this crucial dimension needs to be considered and worked upon right from the early phases. NGOs could bring the issue of implementation of the FCTC to the table. They could participate as partners in implementation and could help develop mechanisms to monitor implementation. Policy implementation is problematic, especially in a developing country context, including the Indian subcontinent, for a variety of complex factors. Hence great attention and adequate sustained efforts and resources need to be directed towards implementation. Too often, policy makers rest content with the formulation of a policy. But then, this does not alter the ground reality of tobacco production and use. It could even mask the problem, and could become a placebo policy to inactivate certain constituencies such as the anti-tobacco lobby.

- The risks of non-action and non-implementation

are particularly strong when forces supporting and opposing the policy reflect a great imbalance. This is even more likely when the opposition has strong political and economic interests in seeing that implementation does not occur. Many devious means are employed, as is already evident in the tobacco case. These range from undertaking counter research, producing misleading information, strong use of media and popular icons, attempting to influence legal and political processes, and the use of blackmail. Hence implementation and campaign strategies need to be strong and resourceful enough to outlast and overcome these elements. These dimensions can all be considered an intrinsic part of policy process when dealing with a political issue such as tobacco.

- A stakeholder analysis for each country will be necessary in the development of the FCTC and for other support policies and strategies that are required for effective tobacco control. This would help to identify groups with whom one needs to dialogue and to build coalitions with and, if necessary, to challenge. In the Indian subcontinent, cricket is a passion and national teams are observed with great interest. Recognizing this, tobacco companies sponsor events and teams with players wearing the company name and logo prominently on their clothing and other gear. NGOs such as VHAI have been for the past few years corresponding and dialoguing with the Board of Cricket Control of India (BCCI) and with state clubs, umpires and players, as a group. This is being used by companies who have a strong stake in promoting their product. The cricket group with different interests and stakes are perhaps unintentionally but powerfully influencing tobacco use. This was observed in a study of school children after the Wills World Cup in 1996 which found that a significant proportion tried their first cigarette, after their attention was drawn to it, following the sponsored event. Smokers' rights lobbies need to be recognized as a stakeholder group, and some lines of communication, even if they be challenging, need to be established. Most important, NGOs need to build informed and effective public pressure, as a force to counter tobacco industry pressure.

- While the FCTC is important in addressing the powerful TNCs, evidence from the region concerning tobacco use shows major local variations, indicating the need to evolve complementary policies at a national, regional, and state level. For instance, cigarette smoking in India comprises only about 18 to 20 percent of tobacco use. It is probably of the same order or less in the subcontinent. MNC's who will be affected by the FCTC account for only a proportion of this, as Indian companies also produce cigarettes. Price rises, due to increased taxation over several years on cigarettes, have already reduced their sales. Many consumers have switched to [locally produced "cigarettes"called] bidis, and bidi sales have been rising. A recent report found that flavored, imported bidis are fast gaining popularity with youth in the U.S.A. Bidis are produced, packed, and marketed by local producers through unorganized cottage or household-based industries. Bidis are untaxed and are available much cheaper. They are more harmful, containing higher nicotine and tar levels, and they require much more puffing and inhalation to prevent them from going out. Due to the dose-related effects, adverse health consequences of smoking bidis are likely to be even worse than cigarettes. Thus, an unexpected and unintended effect of a very rational and well intentioned policy of increased taxation and pricing of cigarettes that are supposedly safer, is leading to increased consumption of a more harmful form of smoked tobacco.

- Another widespread practice in the subcontinent is the use of chewing tobacco, locally called gutkha, khaini, mishri, pan masala, etc. Recent studies in Mumbai found that 75 percent of adult men and 60 percent of adult women chew tobacco. It is important to note that while smoking rates among women are relatively low, rates of women chewing tobacco are high. Tobacco chewing starts as early as eleven to 13 years of age. It is strongly addictive, as is any nicotine use. High rates of precancerous submucous fibrosis and oral and upper alimentary cancers have been reported and causally associated. Chewing tobacco accounts for 30 percent of tobacco use in India. It is processed and marketed both by national and small local companies. Both the above factors point to the urgent need to address issues concerning the bidi and gutkha industry. The problems here are more complex, as this is a large, extensively spread out, unorganized sector. It also provides employment, particularly to poor women and children, most of whom are undernourished, have little formal education, and who also suffer from occupational health hazards of handling and working with tobacco. These workers have

little social security and are not informed of the risks of their work. Hence even in tobacco policy, one comes face to face with societal issues concerning poverty, gender, and inequality.

- The tobacco campaign appears not yet to have given specific attention to issues concerning inequity, though general mention is made of it and undoubtedly the FCTC in itself is taking an explicit political position. Perhaps there is need for greater analysis and understanding of the tobacco issue from this perspective at the national and global levels. Here, one will have to deal with tobacco production and processing and sales in the large unorganized sector and with issues of alternate employment and alternate crop production. Ongoing discussions are needed with workers' groups and unions, with agricultural laborers and landowning tobacco farmers, and with different ministries of government. National and local contextual issues such as gender, age, and work also need consideration. International support and solidarity, offered in a sensitive way, may help policy and political processes at these levels, too.

- Cross-cutting linkages between tobacco and alcohol, drugs, consumerist cultures, and lifestyle issues including those dealing with individualism and freedom are also not addressed, though they are closely intermeshed.

- While some NGOs are issue based, several others are community based and one of the NGOs' strengths is closeness to people. They are often catalysts for peoples' organizations and may be part of, or support peoples' social movements. Community-based NGO work in India, for instance, is large, with more than 5,000 voluntary organizations working specifically in the health sector, being members of national networks such as the Voluntary Health Association of India (VHAI), the Catholic Health Association of India (CHAI), the Christian Medical Association of India (CMAI), a medico friend circle, and others. Several thousand more NGOs work in development, environment, education, women's issues, and other fields. Community based, they usually are flexible and have a broad scope in their work interventions, with activities covering a range of issues important for that particular community.

- Tobacco-control work is already being under taken by some groups and could easily be introduced by many others. The training of community health workers in preventive education, in tobacco cessation activities, and in campaigning is an area that could be pursued more strongly.

- From a policy point of view, a more focused campaign concerning itself with tobacco needs to develop good working links with community-based NGOs, with central and local government bodies, and several other groups.

- Care needs to be taken that the tobacco campaign and the Tobacco Free Initiative should not become too narrow or be seen as another vertical programme. The dialectics between the need for focused work in order to achieve specific results needs to be balanced against the complexity of reality and the realization that diverse creative efforts can all work towards the "cause," intentionally and perhaps sometimes unintentionally. For instance, culture and religion in the subcontinent provide a social barrier or disincentive to smoking among some groups, and especially for women. Put positively, culture and religion provide motivation and role models for healthy living.

- What should be one's position vis-à-vis supporting these societal dimensions that have been developed and cherished over centuries by one of the oldest civilizations in the world? Though there may be aspects of the same culture and religion that may need transforming, it is evident that mere modernization, of which lifestyle and tobacco use are symbols, are inadequate in providing meaning to life. Reinforcing positive elements of traditional values and relationships may help to fill or answer an inner void or search which maybe one of the psychosociocultural reasons for tobacco use and other addictions. It has been observed that while governments may be weak or unstable in the Indian subcontinent, society and societal mores are strong. This needs to be recognized and strengthened and utilized during tobacco control or any health work.

Conclusion

In conclusion, the voluntary sector in the Indian subcontinent is widespread and vibrant. It has already made major contributions to tobacco-control work. It has over the years developed experience and alternate expertise that could well be utilized in

the development of the FCTC. NGOs will need to be involved in the early stages of the processes both of policy development and implementation. The participation of representatives from the various peoples' groups that are affected should also be ensured. A consultative process between international agencies, governments, NGOs, academic bodies, and peoples' organizations can enhance the development and formulation of the FCTC. The need to understand local patterns of tobacco use and different dimensions of the tobacco industry is important. Most important, implementation and monitoring issues need careful consideration at the formulation stage itself.

HIGHLIGHTING NGO LINKAGES TO PROMOTE THE TOBACCO FREE INITIATIVE

Dr. Elizabeth L. Bowen
International Liaison, Health for Humanity

By focusing on linkages, those of us who are active in the NGO Community have marvelous opportunities to strengthen our efforts to eradicate tobacco. Consider, for example, the potential for NGOs to enhance tobacco-control efforts in the context of the diverse themes of the series of United Nations Summits.

In 1990, the Children's Summit was the first of the global conferences. I doubt that anyone in this room would promote tobacco for children. There seems to be universal consensus that that is not a moral or principled thing to do. Have you ever met a parent who wanted his or her child to smoke?

The Platform for Action of the Fourth World Conference on Women and Development, soon to be reviewed during the "Beijing Plus Five" meetings, has a strong focus on women's health. One potential focus for activists in NGOs working on women's health is the importance of upholding the avoidance of tobacco use by women and girls as a beneficial social value. Another potential focus is to ban tobacco advertising directed at women.

The Human Rights Summit is another focus that the NGO Community can use to create strong linkages. It is a human right not to smoke and it is a human right not to be exposed to tobacco smoke. This appeal can be directed to concerned citizens of all ages. For example, NGOs at local, national, and global levels can play influential roles in creating social climates in which smoke-free environments are expected and respected. NGOs can also educate the general public not to smoke and especially not to smoke around infants, children, youth, women, or the aged. NGOs can also use a human rights-based approach to ban tobacco promotion in the media. NGOs could mobilize human rights groups and medical, legal, and other professional associations worldwide on that focus, from the compelling perspective of health and human rights.

The Earth Summit in Rio and Habitat II in Istanbul dealt with issues of environment and human settlements. The indoor environment is especially relevant. For example, we each have the right not to be exposed to tobacco smoke in any public place. This includes all forms of public transportation, businesses, and institutions, including the United Nations. NGOs can both challenge prevailing practices and cite best practices to provide practical examples of effective ways to transform harmful institutional practices.

In reference to the International Conference on Population and Development and its follow-up, tobacco control can be addressed in the context of poverty and crowding in human settlements, and massive population shifts such as migration and urbanization. Those concerned with issues raised at the Food Summit might point out that in certain impoverished economies, as much as 10 percent of family income often goes to buy tobacco, when it would be better spent on necessities such as food. Finally, tobacco-control efforts can be combined with ongoing public health efforts to eradicate tuberculosis, a highly contagious disease that is compounded by smoking and crowding.

Last week, at The Hague Peace Appeal, a UNESCO official shared the following model to illustrate the diverse capacities, responsibilities, and roles of NGOs. Imagine a rainbow. Each color illustrates unique spheres of action, yet to address social challenges effectively, the full spectrum participates. Red represents emergencies, such as medical and public health crises. Orange stands for reconstruction. Yellow denotes social development. Green signifies economic development, agriculture, and the environment. Blue symbolizes human rights and law. Indigo represents spirituality, religious organizations, and faith communities. Finally, violet is the symbol for synergy, the fruit of collaboration. The rainbow analogy is a vivid example of the unity and diversity reflected in the NGO community as it works for common aims in multiple sectors.

These are powerful themes for us to use to highlight our messages and to mobilize NGOs in the context of their natural linkages and extensive grassroots networks, to develop, promote, ratify, implement, and monitor compliance to the Framework Convention on Tobacco Control. Key themes also can create common ground to sustain collaboration with UN agencies such as WHO, academic institutions, governments, and other NGOs.

As representatives of the rainbow of NGOs within the NGO Forum for Health, you are invited to reflect and to consult with your constituents: How can you best collaborate with each other, with your communities, governments, and the World Health Organization and other UN agencies, on the Framework Convention on Tobacco Control? How can you and your NGOs contribute most effectively to further the goals and objectives of the Tobacco Free Initiative?

NGO Forum for Health Annual Report, 1999

Presented 17 May 1999
Dr. Eric Ram, Chairman

Ladies and Gentlemen:

I am pleased to present to you a summary of the activities of the NGO Forum for Health for the period of May 1998 to April 1999.

In conjunction with the Annual General Assembly, in May 1998 we organized a very successful symposium on the theme, "The Effects of Globalization on Health." This symposium was co-sponsored by the Dag Hammarskjold Foundation of Sweden, World Council of Churches, and the NGO Forum for Health. We were very fortunate to have four excellent speakers in the persons of Dr. Derek Yach, Prof. Giovanni Berlinguer, Prof. David Sanders, and Dr. Jose Tiongco.

Dr. Elizabeth Bowen served as the rapporteur. Thanks to the Dag Hammarskjold Foundation and Dr. Bowen, the report is now available for you to have.

We have maintained our dialogue with the WHO during this crucial transition period for them. On behalf of the Forum, we have met with a number of WHO staff including: Dr. Lyagoubi Ouhachi, the Executive Director of External Relations and Governing Bodies; Dr. Julio Frenk, Executive Director of Evidence and Information for Policy; Dr. Bill P. Kean, Director, Department of External Cooperation and Partnership; as well as Dr. Roberta Ritson, who has helped us throughout the year in many ways.

We had requested a meeting between the NGO Forum and the new Director General of WHO. Unfortunately, that meeting has not materialized.

Our collaboration with other fora has continued. At the invitation of the Council of Europe and the Nordic School of Public Health, I delivered a keynote address in Strasbourg, France, on the topic "Health and Human Rights." Dr. Alireza Mahallati chaired one of the workshops entitled "The Role of the NGOs," and Dr. Mireille Kingma spoke on "Violence in the Health Sector."

At the Annual General Assembly of the Forum, held in Geneva in May 1998, the decision was made to formalize the Forum's membership. As such, the Coordinating Committee has developed the following fee structure:

	CATEGORY	SUGGESTED FEES
1	Benefactor	SFr. 5,000. or US$ 4,000.
2.	Founding Member	SFr. 2,500. or US$ 2,000.
3.	Sponsoring Member	SFr. 1,500. or US$ 1,150.
4.	Supporting Member	SFr. 800. or US$ 600.
5.	Contributing Member	SFr. 400. or US$ 300.
6.	Regular Member	SFr. 200. or US$ 150.
7.	Associate Member (individuals without organizational affiliation)	SFr. 100. or US$ 75.

So far in 1999, 57 paying members have registered with the Forum. More are joining every day. This will help defray the costs associated with the proper functioning of the Forum. World Vision International has provided the office and logistical support while Ms. Sheila O'Byrne has provided the multiple administrative support functions necessary in running the Forum.

We are inviting all NGOs who wish to be a part of this growing influential network of NGOs to both benefit from and contribute to the work of the NGO Forum for Health. We remain an inclusive forum of multi-sectoral NGOs who are committed to promoting equity and justice in health care and wish to partner with others in making health a reality for millions around the world.

A Task Force under the leadership of Dr. Alireza Mahallati has been formed to study and recommend the future structure, organization, and registration of the Forum.

Global Health Watch

One of the major activities of the Forum this year has been the Global Health Watch (GHW), a project undertaken to promote and eventually establish an independent, credible entity to monitor inequality in health and promote implementation of Health For All strategies and the availability of resources toward achievement of equity and justice in health care. A concept paper was developed, and we approached selected donors to help fund a feasibility study. A consultant, Ms. Andrea Mach, was hired who did part one of the three-part feasibility study. A survey was conducted to explore the quantitative contribution NGOs are currently making, with a view to assess how that function might contribute to the future establishment of a Global Health Watch. Ms. Asmita Naik is now helping us with parts two and three of the feasibility study.

As a part of this feasibility study, it is also expected to conduct a six-country field study to obtain regional perspectives on Global Health Watch which, in turn, could also become the nuclei of National Health Watch within the network of Global Health Watch.

NGOs have a unique contribution to make both at the international and national levels in the establishment of the GHW. They can help monitor implementation of agreements and conventions, perform policy analyses, serve as an early warning mechanism, bring citizens' concerns to the attention of the governments and international bodies, provide alternate reports, be advocates for much-needed resource mobilization, et cetera.

We also hope to learn from the experience of other "watches." The output of the workshop of Global Health Watch on 18 May 1999 will be incorporated into the findings of the six-country study as well as the lessons learned from other "watches." Á set of recommendations will be drawn and a final report prepared which will then be sent out to potential donors. It is anticipated that a more formal workshop will be held to present and receive the final report and explore ways of launching a Global Health Watch, possibly in the Year 2000.

Organizations which have contributed so far financially and/or in kind are –

1. NOVIB (The Netherlands)
2. MISEREOR (Germany)
3. DIFAM (Germany)
4. World Vision International (Geneva)
5. ICCO (The Netherlands)
6. Swiss Development Agency (Switzerland) (committed)

Other organizations have also shown their willingness to contribute. We are very grateful to all the donors.

As NGOs, we must not be driven by the UN agendas all the time. Instead, we must set the agenda ourselves and pioneer new ways of partnering among ourselves as well as organizations such as WHO and UNICEF. Let us be more accountable and supportive of each other. Let the voices of the grassroots organizations be more audible and their real success stories be more visible globally, so that we can learn from each other.

As I will have completed three years of my Chairmanship of the Forum this year, it is appropriate that we choose a new Chair and a new Coordinating Committee in time for the Year 2000 activities, to take the Forum to new heights and farther than ever before in our vision for achieving health for all in the 21st Century. The Coordinating Committee will initiate the election process, hopefully soon, and every paying member of the Forum will be eligible to apply for the position in which they can serve best.

May I take this opportunity to express my sincere thanks to all of you for your enthusiastic support, and to the members of the Coordinating Committee, in particular, Dr. Alireza Mahallati, Treasurer; Mr. Giovanni Ballerio, Secretary; and Ms. Sheila O'Byrne, our volunteer administrative support, all of whom have so generously provided assistance in so many ways to the smooth running of the Forum.

Thank you.

Eric Ram, Ph.D.
Chairman

Treasurer's Report for the NGO Forum for Health

Dr. Alireza Mahallati, Treasurer

Summary of the "General Operations" Account, #240-630948.27 F
September 1998 - April 1999

DESCRIPTION	CREDITS	DEBITS	BALANCE
Income from Membership Fees	SFr. 26,027.25		
Expenses to Date		SFr. 2,785.55	
Balance as of 30.4.99			**SFr. 23,241.70**

This report contains all payments made into the "General Operations" account up until the 30 April 1999. No pledges have been shown.

"General Operations" Account, #240-630948.27 F
September 1998 - April 1999

MEMBERSHIP CATEGORY	NUMBER OF MEMBERS	FEES PAID (in Other Currencies*)	FEES PAID IN SWISS FRANCS	TOTAL IN SWISS FRANCS
Benefactor	One (1)	1X US $ 4000.00		SFr. 5,866.00
Founding Member**	Three (3)	1X US $ 2000.00	(2 members) SFr. 7000.00	SFr. 9,905.00
Sponsoring Member	One (1)		(1x) SFr. 1600.00	SFr. 1,600.00
Supporting Member	One (1)		(1x) SFr. 800.00	SFr. 800.00
Contributing Member	Three (3)	(2 members) US $ 600.00	(1x) SFr. 400.00	SFr. 1,253.30
Regular Member***	Thirty-nine (39)	(20 Members) US $ 2,870 & 1 X UK £95	(19 members) SFr. 3,300.00	SFr. 6,298.35
Individual Member	Three (3)	US $ 75.00	(2 members) SFr. 200.00	SFr. 302.60
Totals	Fifty-one (51)	US $ 9545.00 UK £ 95.00	SFr. 13,300	**SFr. 26,027.25**

Charges and Expenses

TYPE	DATE	AMOUNT
UBS banking charges	1.12.98 to 31.3.99	SFr. 139.55
Fees for cheques	1.12.98 to 31.3.99	SFr. 50.00
Payment of stipend to the volunteer/intern	1.12.98 to 30.4.99	SFr. 2,500.00
Payment of cheque for office equipment	1.12.98 to 31.3.99	SFr. 96.00
TOTAL		**SFr. 2,785.55**
BALANCE		**SFr. 23,241.70**

* Fees paid in currencies other than Swiss Francs have been converted to SFr. by the UBS bank at the prevailing exchange rate.

** World Vision International have paid for two years membership, which have been reflected in this report. World Council of Churches paid before the membership rates were agreed.

*** Includes adjusted rates for members from developing countries.

Summary of the "General Operations" Account, #240-630948.27 F
September 1998 - April 1999

DESCRIPTION	CREDITS	DEBITS	BALANCE
Income from Contributions	43,154.09		
Expenses to Date		SFr. 7,260.50	
Balance as of 30.4.99			**SFr. 35,893.59**

This report contains all payments made into the "General Operations" account up until the 30th April 1999.
No pledges have been shown.

"Global Health Watch" Account, #240-630948.29 Z
September 1998 - April 1999

DETAIL	CREDITS	AMOUNT
Contributions made by:		
BUSCO	1.9.98 to 30.4.99	
ICCO		
DIFAM		
NOVIB		
MISEREOR		
TOTAL		43,154.09

Charges and Expenses

TYPE	DATE	AMOUNT
UBS banking charges	1.9.98 to 30.4.99	SFr. 10.50
Payment for cheques	1.9.98	SFr. 50.00
Payment of consultant	24.9.98	SFr. 7,200
TOTAL		SFr. 7,260.50

BALANCE	FR. 35,893.59

* Including interest given by UBS bank.

Addendum

Tobacco Free Initiative: Executive Summary

By World Health Organization Staff

According to WHO estimates, there are currently 3.5 million deaths a year from tobacco, a figure expected to rise to about 10 million by 2030. By that date, based on current smoking trends, tobacco is predicted to be the leading cause of disease burden in the world, causing about one in eight deaths. Seventy percent of those deaths will occur in developing countries. The sheer scale of tobacco's impact on global disease burden, and particularly what is likely to happen without appropriate intervention in developing countries, is often not fully appreciated. The extremely negative impact of tobacco on health now and in the future is the primary reason for giving explicit and strong support to tobacco control on a worldwide basis.

In response to these concerns, the Director General, Dr. Gro Harlem Brundtland, established a Cabinet project, the Tobacco Free Initiative (TFI), in July 1998 to coordinate an improved global strategic response to tobacco as an important public health issue. The long-term mission of global tobacco control is to reduce smoking prevalence and tobacco consumption in all countries and among all groups, and thereby reduce the burden of disease caused by tobacco. In support of this mission, the goals of the Tobacco Free Initiative are to:

- Galvanize global support for evidence-based tobacco control policies and actions;
- Build new, and strengthen existing, partnerships for action;
- Heighten awareness of the social, human, and economic harm of tobacco in all sectors of society, and the need to take comprehensive actions at all levels;
- Accelerate national, regional, and global strategic planning, implementation, and evaluation;
- Commission policy research to suggest rapid, sustained, and innovative actions;
- Mobilize adequate resources to support action;
- Integrate tobacco into the broader agenda of health and development; and
- Facilitate the development of an effective Framework Convention for Tobacco Control and related protocols.

In achieving these goals, the Tobacco Free Initiative will build strong internal and external partnerships "with a purpose" with each WHO Cluster and Regional and Country Offices, and with a range of organizations and institutions around the world. The purpose of these partnerships will reflect the unique and complementary roles of WHO's partners and of WHO at all levels of the organization. Success will be measured in terms of actions achieved at local, country, and global levels that lead to better tobacco control.

The Tobacco Free Initiative will take a global leadership role in promoting effective policies and interventions that make a real difference to tobacco prevalence and associated health outcomes. Despite the seriousness of the problem, there is evidence to show that countries which undertake concerted and comprehensive actions to address tobacco control can bring about significant reductions in tobacco-related harm. These success stories indicate the importance of considering the best mix of specific interventions required to achieve the same goal: increased cessation and lowered initiation. The specific mix of interventions in a broad policy framework will vary according to each country's political, social, cultural, and economic reality.

Critical to the success of these global tobacco control actions will be the ability to mobilize human, institutional, and financial resources to support enhanced activity. Current allocations at regional and global levels are severely inadequate, especially when faced with a $400-billion industry which promotes these harmful tobacco products. Increased allocations will enable improved international research, policy development, and action to address the massive public health impact of tobacco.

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The NGO Forum for Health

Partnering to make health a reality
Promoting equity and justice in health care

Founding Members: World Vision International, Geneva; World Council of Churches, Geneva; Medical Professionals Alliance, Taiwan; Global Health Council, Washington, D.C.

For Further Information

The NGO Forum for Health is an inclusive association of multi-sectoral non-governmental organizations who are committed to promoting equity and justice in health care and wish to partner with others in making health a reality for millions around the world.

We invite all NGOs who wish to be a part of this growing influential network both to benefit from and contribute to the work of the NGO Forum for Health.

For further information, please contact either Mr. Ballerio or myself at the addresses below.

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